SAMPLE FORM

Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child’s name, name of medication, directions for medication’s administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper’s departure at the end of camp.

Authorized Prescriber’s Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _________________________ Date of Birth ____/____/____ Today’s Date ____/____/____

Medication Name __________________________________________ Controlled Drug? ☐YES ☐NO

Dosage ___________________ Method ________________ Time of Administration __________________

Specific Instructions for Medication Administration _____________________________________________

Medication Administration: Start Date _____/_____/____ Stop Date _____/_____/____

Is this medication to be self-administered by the child? ☐Yes ☐No

Relevant Side Effects of Medication _________________________________________________________

Plan of Management for Side Effects _______________________________________________________

Known Food or Drug Allergies? ☐YES ☐NO Reactions to? ☐YES ☐NO Interactions with? ☐YES ☐NO

If “yes” to any of the above, please explain ___________________________________________________

Prescriber’s Name_____________________________________ Phone Number (_____) ______________

Prescriber’s Address ___________________________________________ Town ____________________

Prescriber’s Signature __________________________________________

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above.

☐ I request that medication be self-administered to my child as described and directed above.

Name of Camp _____________________________________________ Today’s Date ______/_____/____

Child’s Name ______________________ Address ___________________________ Town_____________

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name ______________________ Last Name _________________________

Relationship to Child: ☐Mother ☐Father ☐Guardian/Other explain: ________________________________

Address __________________________ Town ______________ Phone Number (_____) __________

Signature of Parent/Guardian Authorizing Administration of Medication _____________________________

Name of Camp Personnel Receiving Written Authorization and Medication

Title/Position __________________ Signature (in ink) ____________________________
Medication Administration Record (MAR)

Name of Child ___________________________________________ Date of Birth ______/______/______
Pharmacy Name __________________________________________ Prescription Number _______________
Medication Order__________________________________________________________________________

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<th>Date</th>
<th>Time</th>
<th>Dosage</th>
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<th>Was This Medication Self Administered?</th>
<th>Signature of Person Observing or Administering Medication</th>
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*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete  ☐ Medication is appropriately labeled
☐ Medication is in original container  ☐ Date on label is current

Person Accepting Medication (print name)________________________________________ Date _____/_____/______