

**YMCA Day Camp Torymca**

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS**

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

**AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Condition for which drug is being administered during camp hours \_\_\_\_\_

DRUG: Name of Drug, Dose and Method of Administration \_\_\_\_\_

Times of Administration: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Medication shall be administered from \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Allergies, reaction to, or negative interaction with food or drugs? If YES, list \_\_\_\_\_

This drug may be self administered by this child:  Yes  No

The authorized prescriber's or Dentist's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

(Type or Print)

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Authorized Prescriber or Dentist's Signature \_\_\_\_\_

**Authorization by Parent/Guardian for the administration of the above medication:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child \_\_\_\_\_, be administered by the nurse or by camp personnel with current Medication Administration Training.

I give permission for the above medication to be self administered:  Yes  No

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian \_\_\_\_\_ Signature \_\_\_\_\_

(Print Name)

Relationship to child \_\_\_\_\_ Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_