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.

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_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*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** _____/_____/_____