



# Medication Authorization Form

Please return to: **Community Music School**, P.O. Box 387, Centerbrook, CT 06409

**Due within two weeks of receiving this packet**

## Authorization for the Administration of Medication (if applicable)

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 \_\_\_\_\_

### OFFICE USE

Name of Camp Personnel Receiving Written Authorizing and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature (in ink) \_\_\_\_\_

S1  S2  S3  S4  S5  SSP