



Star Hill Family Athletic Center
Summer Recreation Camp
Authorization for the Administration of Medication

In Connecticut licensed youth camps, administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the camp with appropriate written authorization(s) and the medication **before** any medications are administered. **Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.**

Authorized Prescriber's Order

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Address of Child _____ Town _____

Medication Name/Generic Name of Drug _____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions of Medication Administration _____

Dosage _____ Method _____ Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date ____/____/____ Stop Date ____/____/____

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescribers Signature _____ Date ____/____/____

Parent/ Guardian Authorization:

I request that medication be administered to my child as described and directed above and I attest that, with the exception of emergency medication, I have administered at least one dose of the medication to my child without adverse effects.

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

Name (printed) _____ Signature _____

Relationship to Child _____ Date _____

Address _____ Town _____ State _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____

Is this Medication to be self-administered by the child? YES NO

If Yes, Prescriber's authorization for self-administration (signature/date) _____

If Yes, Parent/Guardian's authorization for self-administration (signature/date) _____

*****STAR HILL USE ONLY *****

Name of Individual Receiving Written Authorization and Medication _____

Today's Date _____ Title/ Position _____ Signature (in ink) _____