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)** _____