



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# Authorization for the Administration of Medication by Mountain Mist Day Camp Nursing Staff

**\*\*This form only needs to be filled out by a doctor if your son/daughter will be taking any medications while at Mountain Mist Day Camp.**

In Connecticut, any licensed camp administering medications to children shall comply with all CT State statutes and regulations for administering medications. Parents/Guardians requesting medication administration to their child from the camp nursing staff shall provide Mountain Mist Day 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, the name of the medication, directions for medication's administration and the date of the prescription. All unused medication will be disposed of properly at the end each session (unless your child is attending multiple sessions).

### **Authorized Prescriber's Order** (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Medication Name: \_\_\_\_\_ Controlled Drug? Yes \_\_\_ No \_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time of Administration: \_\_\_\_\_

Specific Instructions for Medication Administration: \_\_\_\_\_

Medication Administration: Start Date: \_\_\_/\_\_\_/\_\_\_ End Date: \_\_\_/\_\_\_/\_\_\_

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: \_\_\_\_\_

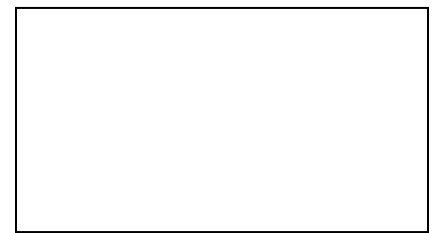
This medication is an emergency medication and NOT a controlled substance, and the camper is authorized to carry and self-administer the above prescribed medication: Yes \_\_\_ No \_\_\_

Prescriber's Name: \_\_\_\_\_

Prescriber's Address: \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_



Use for Prescriber's Stamp

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### **Parent/Guardian Authorization:**

I request that medication be administered to my child by the Mountain Mist Nursing Staff as described and directed above, and agree to provide the camp with the medication according to CT Regulations described above, in a quantity appropriate for my child's camp experience.

If applicable, I authorize my child to carry and self-administer the above prescribed emergency medication Yes \_\_\_ No \_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_