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

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:____/_____/_____