Medical Authorization Form Camp Jewell YMCA

In Connecticut Lcensed 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 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.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

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

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End 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 _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by camp personnel and I give permission for the exchange of information between the prescriber and the camp nurse necessary to ensure the safe administration of this medication.

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects.

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

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

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by an authorized prescriber.

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____

Presribers authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

PLEASE NOTE **ALL PRESCRIPTION MEDICATIONS** MUST BE IN THE PHARMACY PREPARED CONTAINERS AND LABELED WITH THE NAME OF THE CHILD, NAME OF THE DRUG, STRENGTH, DOSAGE, FREQUENCY, AUTHORIZED PRESCRIBERS NAME AND DATE OF THE ORIGINAL PRESCRIPTION.
OVER-THE-COUNTER MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILDS NAME.
FOR EPI PENS AND ASTHMA INHALERS- FOR YOUR CHILD TO BE ABLE TO SELF ADMINISTER YOU MUST CHECK YES AND SIGN FOR SELF ADMINISTRATION. WE RECCOMEND THAT YOU SEND 2 INHALERS IF POSSIBLE SO THAT WE CAN HAVE A SPARE IN THE HEALTH CENTER.

PLEASE MAKE AS MANY COPIES OF THIS FORM AS NECESSARY. YOU MUST HAVE **ONE FORM FOR EACH** PRESCRIPTION OR OVER-THE-COUNTER MEDICATION YOU SEND WITH YOUR CHIOLD TO CAMP