



MAHACKENO OUTDOOR CENTER

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICINES

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A., APRN) or dentist's written order and the parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency authorized prescriber or dentist's name and the date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

ALL UNUSED MEDICATION WILL BE DESTROYED IF NOT PICKED UP WITHIN ONE WEEK OF THE LAST DAY OF CAMP

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: DATE ____/____/____

Authorized Prescriber's Order-Physician or Dentist (please complete all the following information)

NAME OF CHILD: _____ DOB: ____/____/____ TODAY'S DATE: ____/____/____

ADDRESS: _____ TOWN: _____ STATE: _____ ZIP: _____

MEDICATION NAME: _____

CONDITION FOR WHICH DRUG IS BEING ADMINISTERED DURING CAMP HOURS: _____

TIME OF ADMINISTRATION: _____ MEDICATION SHOULD BE ADMINISTERED FROM ____/____/____ TO ____/____/____

CONTROLLED DRUG? YES__ NO__ DOSAGE: _____ METHOD: _____

SPECIFIC INSTRUCTIONS FOR MEDICATION ADMINISTRATION: _____

RELEVANT SIDE EFFECTS: _____

PLAN OF MANAGEMENT FOR SIDE EFFECTS: _____

ALLERGIES, REACTION TO OR NEGATIVE INTERACTION WITH FOOD OR DRUGS? IF YES, LIST _____

AUTHORIZED PRESCRIBER OR DENTIST'S NAME: _____ PHONE: _____

STREET ADDRESS: _____ CITY/TOWN _____ STATE _____

PHYSICIAN/DENTIST SIGNATURE: _____ DATE: _____

PHYSICIAN/DENTIST STAMP: _____

PARENT/GUARDIAN AUTHORIZATION:

For the administration of the above medication by the Westport Weston Family Y personnel. I attest that I have administered at least one dose of the medication to my child without adverse effects.

I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by Westport Weston Family Y personnel. I understand that I must supply the Westport Weston Family Y with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 day supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the camp program.

Parent/Guardian Signature: _____ Date: _____

Name of Childcare Personnel Receiving written Authorization and Medication _____

Title: _____ Signature: _____ Date: _____

