Authorization for the Administration of Medications

Koinonia School of Sports

PO Box 321, Thompson, CT 06277
(860)928-6420

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 parent or guardian's authorization for a nurse or camp personnel with current Medication 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 date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

Authorized Prescriber or Dentist's Order : Date ___/___/___

Name of Child:_____ Date of Birth ___/___/___
Address:_____ Town:_____ State:_____
Condition for which drug/medication is being administered during camp hours:_____
_____
Drug/Prescription Information :(Name of Drug, Dosage, and Method of Administration)_____
_____

Time of Administration:_____ Dates Medication shall be administered from:___/___/___ -___/___/___

Relevant side effects to be observed, if any:_____

Is this a controlled drug (please circle) : YES / NO

Allergies, reaction to, or negative interactions with food or drugs? If YES, please list: _____
_____

Authorized Prescriber or Dentist's Name: _____
Address:_____ Town:_____ State:_____

X **AUTHORIZED PHYSICIAN/ DENTITST'S SIGNATURE:**_____

X **Physician/Dentist's Signature for SELF–ADMINISTRATION:**_____

PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATIONOF ABOVE MEDICATION(please circle) YES / NO

I hereby request that the above medication, ordered by an authorized prescriber / dentist for my child _____, be administered by the nurse or by camp personnel with current Medication Administering Training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medication shall be in the original container labeled by the parent/guardian with the child's name. I understand that this medication will be destroyed if it is not picked up one week following termination of the order.

Name of Parent/Guardian :_____
Relationship to child: _____ Phone #:_____
Street Address:_____ Town:_____ State:_____

X **Parent/Guardian Signature:**_____ **Date:**_____

X **Parent/Guardian Signature for Self-Administration:**_____