KEVIN OLLIE BASKETBALL CAMP

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY YOUTH CAMP PERSONNEL

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 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 date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER ORDER DATE: ___________________/______/______

Name of Camper____Date of Birth _____/____/____

Street Address_________________________________City/Town______________________State ________

Condition for which medication is being administered during camp hours____________________________________

Medication (Name of Drug, dose, and method of administration)____

Is this a controlled drug? ____________________

Times of Administration: Breakfast Lunch Dinner Bedtime As Needed Other:______________________________

Medication shall be administered from ___/______/______ to ____/______/______

Relevant side effects to be observed, if any____

If there are side effects, plan for management____

Allergies, reaction to, or negative interaction with food or drugs? If YES, explain/list____________________________

____

Authorization by Prescriber for administration of above medication:

Prescriber's name____Phone # (______)___________

Street Address___________________________City/Town______________________State________

Prescriber's Signature_______________________________________Date_____________________

Authorization by Parent/Guardian for the administration of the above medication:

I hereby request that the above medication, ordered by the authorized prescriber for my child be administered by the camp personnel with current Medication Administration Training.

I understand that I must supply the Kevin Ollie Basketball 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 with the child's name.

I understand that this medication will be destroyed if it is not picked up with in one (1) week following termination of the order/camp.

Parent/Guardian Name_______________________________________Relationship________________

Street Address___________________________City/Town______________________State________

Phone # (______)__________________

Signature____Date_____________________

Authorization/Approval for Self-Administration of above medication:

Self-administration of medication may be authorized by the prescriber and parent/guardian approval for only asthma medication and epi-pens.

Prescriber's authorization/approval for self-administration: Yes No ______________________________
Signature Date

Parent/Guardian's authorization/approval for self-administration: Yes No ______________________________
Signature Date