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 OR DENTIST'S 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 or Dentist'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/dentist 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