Medication Authorization Form

Please return to: Community Music School, P.O. Box 387, Centerbrook, CT 06409

Due within two weeks of registering for the program

Authorization for the Administration of Medication (if applicable)

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp 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. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

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

Name of Child _____Date of Birth ___/___/___ Today's Date ___/___/___

Medication Name _____ Controlled Drug? □ YES □ NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date _____/_____/_____ Stop Date _____/_____/_____

Is this medication to be self-administered by the child? □ YES □ NO

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? □ YES □ NO Reactions to? □ YES □NO Interactions with? □ YES □ NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (_____)_____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization:

□ I request that medication be administered to my child as described and directed above.

□ I request that medication be self-administered to my child as described and directed above.

Name of Camp _____ Today's Date _____/_____/_____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _____ Last Name _____

Relationship to Child: □ Mother □ Father □ Guardian/Other explain: _____

Address _____ Town _____ Phone Number _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

OFFICE USE

Name of Camp Personnel Receiving Written Authorizing and Medication _____

Title/Position _____ Signature (in ink) _____

☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ S5 ☐ **SSP**