

DAN HURLEY 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'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 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 Dan Hurley 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 _____