AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION (EPI-PEN AND INHALERS) AT CAMP

It is important to note that the Summer Place Camp covers a large geographic area on campus. Campers are not always in close proximity to the nurse. Should an emergency occur, the nurse is notified and does respond but self-administration of Epi-Pens and inhalers may be appropriate. If you and your child's healthcare provider agree that the camper is capable of self-administration, please fill out this side of the form.

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

Name of Child _____ Date of Birth ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

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

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 _____

Self-Administration:

1. I have conferred with this child's parents and feel that this medication may be self-administered.
2. This student has been appropriately instructed regarding self-administration.

_____ _____/_____/_____
Physician's Signature Date

_____ (_____) _____
Address Phone

Permission Of Parent/Guardian For Self -Administration Of Medication

To: Summer Place Camp Date _____

I hereby request that the above medication ordered by _____
Name of Physician
for _____ be self-administered by my child.
Name of Camper

I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician.
I understand it may benefit my child for the camp nurse to be supplied with back-up medication in the event the medication is lost or misplaced.
I give consent for communication between the nurse and the prescriber to ensure safe administration of the medication.

_____ _____
Signature of Parent/Guardian Phone

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY CAMP PERSONNEL

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications as described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child by camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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 will 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 _____/_____/_____

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.
Name of Camp: Summer Place
Child's Name _____ Address _____ Town_____

Name of Parent/Guardian Authorizing Administration of Medication _____

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

Address _____ Town _____Phone Number (_____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Date _____/_____/_____