

**Authorization for the Administration of Medication at Camp**

**THIS FORM ONLY FOR CONNECTICUT  
MUST BE SIGNED BY A PARENT AND BY A PHYSICIAN**

Authorized prescriber (physician or dentist) order date \_\_\_\_/\_\_\_\_/\_\_\_\_

CAMPER NAME \_\_\_\_\_ SEX \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
(STREET) (TOWN) (STATE)

CONDITION FOR WHICH DRUG IS TAKEN \_\_\_\_\_

DRUG NAME AND METHOD OF ADMINISTRATION \_\_\_\_\_

TIMES OF ADMINISTRATION \_\_\_\_\_ TO BE ADMINISTERED FROM \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

THIS MEDICATION IS TO BE SELF-ADMINISTERED BY THE CHILD. \_\_\_ YES \_\_\_ NO

SIDE EFFECTS TO BE OBSERVED, IF ANY \_\_\_\_\_

AUTHORIZED PRESCRIBER (PHYSICIAN OR DENTIST) NAME \_\_\_\_\_ TEL \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(STREET) (TOWN) (STATE)  
(ZIP)

PRESCRIBER'S SIGNATURE - PHYSICIAN OR DENTIST (NO STAMP) \_\_\_\_\_

**PARENT OR GUARDIAN  
AUTHORIZATION FOR THE ADMINISTRATION OF THE ABOVE MEDICATION**

I hereby request that the above medication ordered for my child \_\_\_\_\_  
be administered by camp personnel with current Medication Administration Training unless the physician requested  
self-administration. I understand that I must supply the camp with the prescribed medication in the original container  
and properly labeled by an authorized prescriber or pharmacist. Over the counter medication shall be in the original  
container labeled by the parent with the child's name.

Name of Parent /Gaurdian \_\_\_\_\_ Signature \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Tel ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAIL THIS FORM TO THE CAMP OFFICE AS SOON AS POSSIBLE. AFTER JUNE 15<sup>th</sup> BRING IT TO CAMP.  
NO CAMPER WILL BE ADMITTED TO CAMP WITHOUT HAVING THIS FORM ON FILE AT CAMP.