Sterling Park Day Camp
Medical Form Cover Sheet

Packet E
MEDICATIONS Children

If your child needs any kind of medication regularly taken during the camp day, this is the form that you need. Make a separate copy of this form for each medication that the doctor prescribes for your child.

This needs to be turned in AT LEAST one week before your camp session begins, along with the medication/s.

Thank you

First Aid Director
Day Camp
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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.

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

Name of Child/Student __________________________________ Date of Birth ___/___/___ Today's Date ___/___/___
Address of Child/Student ___________________________________ Town ___________________________
Medication Name/Generic Name of Drug ________________________ Controlled Drug? □ YES □ NO
Condition for which drug is being administered: _____________________________________________________________

Specific Instructions for Medication Administration
Dosage __________________________________ Method/Route ___________________________________________
Time of Administration ____________ If PRN, frequency _____________________________________________
Medication shall be administered: Start Date: ___/___/___ End Date: ___/___/___

Relevant Side Effects of Medication ____________________________________________________________ □ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs ____________________________________________

Plan of Management for Side Effects _________________________________________________________________

Prescriber's Name/Title _________________________________________ Phone Number (___) _____________
Prescriber's Address ___________________________________________ Town ___________________________
Prescriber's Signature _________________________________________ Date ___/___/___

School Nurse Signature (if applicable) __________________________

Parent/Guardian Authorization:
□ I request that medication be administered to my child/student as described and directed above
□ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
□ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature ____________________________________ Relationship __________________ Date ___/___/___
Parent/Guardian's Address ______________________________________ Town ___________________________ State ______
Home Phone # (___) __________ Work Phone # (___) ___________ Cell Phone # (___) ____________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: □ YES □ NO ___________________________ Signature ___________ Date ________

Parent/Guardian authorization for self-administration: □ YES □ NO ___________________________ Signature ___________ Date ________

School nurse, if applicable, approval for self-administration: □ YES □ NO ___________________________ Signature ___________ Date ________

Today's Date __________ Printed Name of Individual Receiving Written Authorization and Medication ____________________________
Title/Position ___________________________ Signature (in ink or electronic) __________________________

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)
Medication Administration Record (MAR)

Name of Child/Student ___________________________ Date of Birth _____/_____/_____
Pharmacy Name ________________________________ Prescription Number _______________
Medication Order _______________________________

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<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Remarks</th>
<th>Was This Medication Self Administered?</th>
<th>Signature of Person Observing or Administering Medication</th>
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*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete ☐ Date on label is current
☐ Medication is appropriately labeled
☐ Medication is in original container

Person Accepting Medication (print name) ___________________________ Date _____/_____/_____