the children's museum
Where Science and Nature Are Fun

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

THIS FORM MUST BE FILLED OUT IF A CHILD NEEDS TO TAKE MEDICATION DURING CAMP HOURS.

The Children's Museum 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 appropriate written authorization(s) and the medication BEFORE any medications are administered. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the medication, directions for medication's administration, prescriber's name, and the date of the prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER'S ORDER (Physician, Dentist, Physician Assistant, Advanced Practice RN)
(Prescriber's Order is REQUIRED for all medications other than non-prescription topicals)

Date: / /

Name of Child: _____ Date of Birth / /

Medication Name _____ Controlled Drug? Yes _____ No _____

Dosage _____ _____ Method _____ _____ Times 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/ Drug Allergies? Yes ____No ____ Reactions to? Yes ____No ____ Interactions with? Yes ___No ___

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

Authorized Prescriber's Name: _____ Phone (___)_____

Prescriber's Address _____ Town _____ State _____

Authorized Prescriber's Signature: _____

PARENT/GUARDIAN AUTHORIZATION

Parent/Guardian Authorization is REQUIRED for all topical, oral, and inhalant medication applications.

It is recommended for any application ie. sunscreen, insect repellant

I request that medication be administered to my child as described and directed above. I understand and agree to the terms indicated in the shaded box above. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Child's Name _____ Name of Camp _____

Street Address _____ Town _____ State _____

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

First Name _____ Last Name _____ Relationship to child _____

Signature of Parent/Guardian _____ Date / /

Street Address _____

City/Town _____ State _____ Zip _____Phone (___) _____

FOR CAMP USE: Staff who received written authorization & medication _____

Title/Position _____ Signature (in ink) _____