Avon Old Farms A SUMMER CAMPS

Self Administration of Medication Authorization Form

Camper Name: _____ Date of Birth: ____/____/_____

Medication: _____

The camper named above has been instructed in the proper administration of the medication listed. We, the camper's physician and parent/guardian, request that this camper be permitted to self-administer this prescription medication. We consider him/her responsible for its administration. We authorize him/her to do so. He/she has been instructed in and understands the purpose and appropriate method, frequency, dosage, and use of his/her medication.

We, the undersigned, acknowledge that we have read the Administration of Medication Policy and we agree to abide by its provisions.

We, the undersigned, release the Avon Old Farms Summer Camps and its employees of any and all liability resulting from this camper's possession and self-administration of his/her medication. We acknowledge that, from this day forward, Avon Old Farms Summer Camps assumes no supervisory responsibility over the student's self-administration of the above-listed medication(s).

_____
Physician Name – Please Print

_____
Street Address | City | State | Zip Code

_____ _____
Physician Signature | Date

_____
Parent/Guardian Name – Please Print

_____
Street Address | City | State | Zip Code

_____ _____
Parent/Guardian Signature | Date

Avon Old Farms A SUMMER CAMPS

Prescription Medication Authorization Form

In Connecticut, licensed Camps administering medications to children 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 the program with appropriate written authorization(s) and the medication before any medications are administered. Parents/guardians requesting that their child be allowed to self-administer medications shall provide the program with appropriate written authorization(s) and the medication. Medications must be in the original container and labeled with child's name, name of medication, directions for the medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp. Any change in medication, dose, or frequency will require a new form from the physician.

The following information to be completed by a physician only

*Student Name*_____ *Date of Birth*____/____/____

*Diagnosis*_____

Drug Name:	*Dosage:*
Method/Route:	*Frequency of Administration:*
Controlled Drug? ☐ *Yes* ☐ *No*	*Time of Administration:*
If yes, DEA #: _____	

Relevant Side Effects of Medication	*Plan of Management for Side Effects*
Does the camper have any known food or drug allergies? ☐ *Yes* ☐ *No*	*If Yes, please explain:*

May this medication be self-administered by the child? ☐ ***Yes*** ☐ ***No***

_____
Physician Name – Please Print

_____
Street Address | City | State | Zip Code

_____ _____
Telephone Number | Fax Number

_____ _____
Physician Signature | Date