



Day Camp

(Attach photo of camper here)

PERMISSION TO PERMIT MEDICATION

203.355.1151 Camp Fax

203.322.6941 x 122 Camp Nurse (8:30am-4:00pm during camp season)

Connecticut State Law and Regulations require the physician's or dentist's written order and the parent/guardian's signed authorization for the camp nurse or a trained First Aider to administer any medication. Each medication must have a separate Authorization to Administer Medication Form completed by the physician/dentist and the parent/guardian.

Parents/guardians requesting medication administration to their camper while at camp shall provide the camp nurse with appropriate written authorization(s) and the medication before any medication will be administered. Medications must be in the original pharmacy prepared containers and labeled with the camper's name, name of the drug, strength, dosage, frequency, physician/dentist's name and the date of the original prescription. Any "over the counter" medications must be in the original container and labeled with the camper's name. Each Permission to Permit Form and the original container of the medication must have a photograph of the camper that the medication is to be dispensed to.

It is the responsibility of the parent/guardian to deliver any medication and forms to the camp nurse directly.

PHYSICIAN / DENTIST ORDER

Name of Camper \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which this drug is being administered during camp hours: \_\_\_\_\_

MEDICATION INFORMATION

Name of Drug \_\_\_\_\_

Dosage \_\_\_\_\_ Method of Administration \_\_\_\_\_

Dates of Administration ~ Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Other: \_\_\_\_\_

Times of Administration ~ \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

Relevant Side Effects: \_\_\_\_\_

Plan of Management for Side Effects: \_\_\_\_\_

Is this drug a controlled medication? [ ] Yes [ ] No

Does this camper have any known:

Allergies to food or any medication? [ ] Yes [ ] No

Reactions to food or medication? [ ] Yes [ ] No

Interactions with medications? [ ] Yes [ ] No

If the answer to any of the above questions is yes, please explain: \_\_\_\_\_

Prescriber's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician/Dentist's Signature

Date

***This form is only to be returned to the camp when the Italian Center Day Camp has to dispense medication while the camper is at camp, or if medication has to be kept onsite as a precautionary measure (i.e. Epipen, Inhaler, Benadryl, etc).***

I, \_\_\_\_\_, hereby request that the above medication, ordered by the  
Parent/Guardian's Name  
Physician/Dentist for my camper, \_\_\_\_\_, be administered by The Italian Center Day Camp nurse or trained First Aider. I will provide the day camp with an Authorization to Administer Medication for each of the medications that are necessary. I understand that I must supply the day camp with the prescribed medication in the *original container dispensed and properly labeled by the pharmacist. Any "over the counter" medication must be in the original container and must be labeled.*

I hereby grant permission to the Italian Center Day Camp to maintain all medical equipment and medications to be stored in the camp nurse's station throughout my camper's enrollment at camp.

I understand that it is my responsibility to deliver and pick up all medications directly to/from the camp nurse. Furthermore, I understand that all unused medications, inhalers, epipens etc, that are not picked up at the nurse's station within one (1 ) week following the termination of this order, will be destroyed or disposed of.

Name of Parent/Guardian \_\_\_\_\_

Relationship to camper [ ] Mother [ ] Father [ ] Guardian [ ] Other *explain* \_\_\_\_\_

Cell phone number \_\_\_\_\_ Home/Work number \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\*\*\*\*\*DAY CAMP OFFICE USE ONLY\*\*\*\*\*

Name of IC Staff person receiving written authorization and medication \_\_\_\_\_

Were all of the appropriate forms and medical supplies provided? [ ] Yes [ ] No

\_\_\_\_\_  
**IC Staff Signature (Please sign in ink)**

\_\_\_\_\_  
**Date**