



Camper Name: _____

Allergies: _____

Prescription Medication Authorization

*****Please fill out one of these forms for each individual medication.*****

The Connecticut State law and regulations require a physician's written order and parent or guardian's authorization for a nurse to administer medicinal preparations or, in her/his absence, (Section 10-212a)

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

Length of time during which medication shall be administered: June 21, 2019 - June 28, 2019

Condition for which medication is being administered: _____

Name of Medication: _____

Dosage/Route: _____ Time of administration: _____

Relevant side effects to be observed, if any: _____

I give permission for HUH staff to hold Diabetic Supplies: _____
(Syringes/Insulin/Glucometer) Parent / Guardian Initials (if applicable)

MD / DO / APRN - Print name

MD / DO / APRN - SIGNATURE

PARENT SIGNATURE

DATE

Medication should be in the original prescription container labeled with the date, name of drug, dosage, interval, and physician's name and prescription number.