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 19, 2020 - June 26, 2020

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.