



Thames Valley Arts Camp  
 CT College- Box 5294  
 270 Mohegan Avenue  
 New London, CT 06320

## Authorization for the Administration of Medication

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. Medications must be in the original container and labeled with child's name, name of medication, directions for 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.

**Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug?  YES  NO

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time 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 or Drug: Allergies?  YES  NO Reactions to?  YES  NO Interactions with?  YES  NO

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

**Parent/Guardian Authorization:**

I request that medication be administered to my child as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

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

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

**Name of Camp Personnel Receiving Written Authorization and Medication** \_\_\_\_\_

**Title/Position** \_\_\_\_\_ **Signature (in ink)** \_\_\_\_\_



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## Emergency Health Care Plan

Allergy to: \_\_\_\_\_ place child's picture here

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Teacher \_\_\_\_\_

Asthmatic yes\* \_\_\_ no \_\_\_ (\* if yes, then high risk for severe reaction)

### Signs of Allergic Reaction Include:

- MOUTH: itching and swelling of lips, tongue or mouth
- THROAT: itching and/or sense of tightness, hoarseness and hacking cough
- SKIN: hives, itchy rash, swelling about face or extremities
- GUT: nausea, abdominal cramps, vomiting, diarrhea
- LUNGS: shortness of breath, persistent cough, wheezing
- HEART: weak pulse, passing out

**The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life threatening situation.**

### ACTION:

- 1) If ingestion is suspected or bee sting give \_\_\_\_\_
- 2) If symptoms develop give \_\_\_\_\_
- 3) Call Rescue squad if \_\_\_\_\_  
 \_\_\_\_\_
- 4) Call parent or Emergency Contact
- 5) Notify child's physician \_\_\_\_\_ phone \_\_\_\_\_

**Do not hesitate to administer medication or call rescue squad even if parents or physician cannot be reached**

### Emergency Contacts:

- 1) Name \_\_\_\_\_ relationship \_\_\_\_\_ phone \_\_\_\_\_
- 2) Name \_\_\_\_\_ relationship \_\_\_\_\_ phone \_\_\_\_\_
- 3) Name \_\_\_\_\_ relationship \_\_\_\_\_ phone \_\_\_\_\_

Parent signature \_\_\_\_\_ date \_\_\_\_\_

Physican signature \_\_\_\_\_ date \_\_\_\_\_