

# Joe Espinosa's Summer Baseball Camp

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## **AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS – SUMMER 2009**

### **\*PHYSICIAN'S/ DENTIST'S AND PARENT/GUARDIAN SIGNATURES REQUIRED**

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a **physician's or dentist's written order and parent or guardian's authorization** for a certified first-aider to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name. **Medications that have expired will not be accepted.**

#### **PHYSICIAN OR DENTIST'S ORDER:**

Date: \_\_\_/\_\_\_/\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

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

**DRUG:** Name of drug, Dose & Method of Administration: \_\_\_\_\_

When should medication be administered : Date \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ PRN

Relevant side effects to be observed, if any: \_\_\_\_\_

If there are side effects, plan for management: \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Allergies to food or drugs? Yes/No If yes, list: \_\_\_\_\_

Physician's/Dentist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Type or print)

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

**Physician or Dentist's Signature:** \_\_\_\_\_

#### **Authorization by Parent/Guardian for the administration of the above medication:**

Date: \_\_\_/\_\_\_/\_\_\_

To first aider:

I hereby request that the above named medication, ordered by the physician/dentist for my child, \_\_\_\_\_, be administered by the certified first-aider.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

**Name of Parent or Guardian:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

**(Please also see the required GENERAL HEALTH Form)**