The Italian Center Day Camp

1620 Newfield Avenue Stamford, CT. 06905
203-322-6941 ext. 106 (During pre-camp season)
203-322-6941 ext. 122 Nurse's Station (During camp season)
203-355-1151 Day Camp Fax (Year round)

PLACE A PHOTO OF CAMPER

AUTHORIZATION 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 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 Authorized Prescriber & the parent/guardian. This includes not only prescribed medication but "over the counter" medications as well.

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 medications will be administered. Medications must be in *pharmacy prepared containers and labeled with the camper's name, name of the drug, strength, dosage, frequency, physician's or dentist's name and 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 container of the medication MUST HAVE A PHOTO of the camper that the medication is to be dispensed to.

It is the parent/guardian's responsibility to deliver any medication directly to/from the camp nurse during camp hours.

AUTHORIZED PRESCRIBER'S ORDER

Physician, Dentist, Optometrist, Physician Assistant, Advance Practice Registered Nurse or Podiatrist

Camper Name _____ Date of Birth ____/____/____
Camper's Address _____ City _____ today's Date ____/____/____

MEDICATION INFORMATION:

Name of Medication _____ Controlled Drug? [ ] Yes [ ] No
Condition for which this drug is being administered during camp hours

Dosage_____ Method of Administration_____
Dates of Administration: Start Date ____/____/____ End Date____/____/____ Other: _____
Specific Instruction for Medication Administration _____
Time of Administration _____ If PRN, frequency _____
Relevant Side Effects of Medication: _____ [ ] None Expected
Explain any allergies, reaction to/negative interaction with food or drugs _____
Plan of Management for Side Effects:
_____

Does this camper have any known;
Allergies to food or any drug? [ ] Yes [ ] No Explain: _____
Reactions to [ ] Yes [ ] No Explain:_____
Interaction with [ ] Yes [ ]No Explain: _____

ALLERGY PROTOCOL

Please list protocols in the appropriate sequence:

_____ Observe camper for severe symptons
_____ Administer Epipen/Epipen Jr BEFORE symptoms occur
_____ Administer Epipen/Epipne Jr IF symptoms occur
_____ Administer PO Benadryl (dose) _____ or Atarax (dose)_____
_____ Call 911 for transport to Emergency Room if symptoms occur
_____ Call 911 for transport to Emergency Room for observation

***Prescriber's Name* _____**

***Prescriber's Address* _____*City* _____ *Phone Number (___)*_____**
***PRESCIBER'S SIGNATURE* _____Today's Date____/____/____**

AUTHORIZATION BY PARENT/GUARDIAN TO ADMINISTER MEDICATION.

THIS FORM IS ONLY TO BE SENT IN WHEN THE ITALIAN CENTER DAY CAMP HAS TO DISPENSE MEDICATION WHILE THE CAMPER IS AT CAMP, OR IF MEDICATION HAS TO BE KEPT ON SITE AS A PRECAUSIONARY MEASURE (i.e. Epipen, Inhaler, Benadryl, etc)

Today's Date ____/_____/_____

[ ] I request that medication be administered to my camper as described and directed above.
[ ] I hereby request that the above ordered medication be administered by the camp medical staff and I give permission for the exchange of information between the prescriber and the camp medical staff necessary to ensure the safe administration of this medication.
I understand that I must provide the Italian Center Day Camp with an Authorization to Administer Medication for each medication that is needed. I understand that I must supply The Italian Center Day Camp with the prescribed medication *in the original container dispensed and properly labeled by the physician or pharmacist. Any "over the counter" medications must be in the original container and labeled by the parent/guardian.* . *I grant permission for the ICDC to maintain all medical equipment and medications to be stored in the camp nurse's station throughout my camper's enrollment.*
I understand that any/all medications must be delivered directly to the camp nurse by a parent/guardian. Furthermore, I understand that all unused medications, inhalers, epipens etc, that is not picked up at the nurse's station with in one (1) week following the termination of this order.

Name of Parent/Guardian_____
Relationship to Camper: _____Camper Group # _____
Cell Phone _____Work Phone_____ Home Phone _____

PARENT/GUARDIAN SIGNATURE _____Today's Date____/____/_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by parent/guardian and authorized prescriber and must be approved by the camp nurse/administrative staff.

Prescriber's authorization for self-administration:[ ] Yes [ ] No _____
Signature and Date

Parent/ authorization for self-administration:[ ] Yes [ ] No _____
Guardian **Signature and Date**

I.C. Camp authorization for self-administration:[ ] Yes [ ] No _____
Signature and Date

----------THE BELOW PORTION TO BE COMPLETED BY THE DAY CAMP NURSE----------

CAMP PERSONNEL RECEIVING WRITTEN AUTHORIZATION & MEDICATION_____
Print Name

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

SIGNATURE (*in ink*)_____TITLE/POSITION _____

Date Received ____/____/_____ Date Returned____/____/_____