Regional YMCA of Western Connecticut

Greenknoll Day Camp
2 Huckleberry Hill Road
Brookfield, CT 06804

Before June 15, 2017
Phone: (203) 775-4444
Fax: (203) 740-9289

After June 15, 2017
Phone: (203) 775-9363
Fax: (203) 740-3639

ANY AND ALL MEDICATIONS ADMINISTERED AT CAMP MUST HAVE A "AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION" FORM COMPLETED AND MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER LABELED WITH THE CHILD'S NAME.

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date:_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

_____ May participate in all camp activities

_____ May participate except for:

_____

Date of Exam ____/____/____

Medical information pertinent to routine care and emergencies:_____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):_____

ANY MEDICATIONS (prescription or OTC) THAT ARE TO BE ADMINISTERED AT CAMP MUST BE ACCOMPANIED BY AN AUTHORIZATION FORM COMPLETED BY A PHYSICIAN **AND** A PARENT/GUARDIAN.

Does the individual have allergies? ☐ YES ☐ NO Explain**:** _____

Is the individual on a special diet? ☐ YES ☐ NO Explain**:** _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number

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Authorization for the Administration of Medication

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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.**

☐ I request that medication be self-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) _____