Medication at Summer Camp

ASAP! Summer Camp is a State of Connecticut licensed summer camp. This certification requires us to follow strict guidelines with regard to medication at camp. If your child requires medications (including EpiPens and inhalers) while attending camp, every step listed below needs to be completed. Your child will not be allowed to attend camp if we do not have all of the items listed below.

- Complete an Authorization for Administration of Medication Form for each individual medication (CT state form, found on our website). *This form must be signed by the prescribing doctor.

- Complete an Individual Plan of Care for a Child (found on our website) indicating the special health care needs for your child and any other relevant information or precautions that are good for the staff to be aware of.

- Medication must be in the original container and the container must have the prescription label.

- EpiPens must be in the prescription box with the original prescription label or the prescription label needs to be attached to each individual EpiPen case.

- ASAP! Summer Camp requires one EpiPen at camp. The EpiPen will be stored with the First Aid Director for the entirety of the camp.

- All EpiPens, inhalers, and other medications must be taken home at the end of camp.

If you have any questions, please do not hesitate to contact
Ali Psomas, Camp Director at 860-868-0740, ext. 303

Individual Plan of Care for a Child

Child's Name: ___________________________
Date of Birth: ____________________________

Special health care need:

Plan for appropriate care of the child in a medical emergency. An Individual Plan of Care is necessary when a child has a special health care need and it is necessary that special care be taken or provided while the child is at camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s): Date Signed:

__________________________________ ______/_______/_____

__________________________________ _____/_______/______

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Signature of the staff responsible for ____(name of child)

Printed Name Signature Date Signed	Printed Name Signature Date Signed

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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.

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

Name of Child/Student ________________________________ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student ____Town___________________

Medication Name/Generic Name of Drug____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: ____

Specific Instructions for Medication Administration ____

Dosage______________________________Method/Route_______________________________________

Time of Administration _________________________ If PRN, frequency_____________________________

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/______

Relevant Side Effects of Medication ____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs____

Plan of Management for Side Effects ____

Prescriber's Name/Title ____ Phone Number (_____) ______________

Prescriber's Address ____ Town ___________________

Prescriber's Signature ____ Date _____/_____/_____

School Nurse Signature (if applicable) ____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ <u>I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects</u>. (For child care only)

Parent/Guardian Signature___________________________________ Relationship______________ Date ____/____/____

Parent /Guardian's Address ____Town___________________State_____

Home Phone # (_____) ______-________ Work Phone # (_____) ______-________ Cell Phone # (_____) ______-_______

<u>SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL</u>

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO ____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO ____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO ____
Signature Date

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Today's Date ___________Printed Name of Individual Receiving Written Authorization and Medication ________________

Title/Position ______________________________ Signature (in ink or electronic) ___________________________________

<u>Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)</u>

Medication Administration Record (MAR)

Name of Child/Student____ **Date of Birth** ______/______/______

Pharmacy Name ____ **Prescription Number** ______________

Medication Order____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) __________________________________ **Date** _____/_____/____