



Administration of Medication to Campers

In an effort to offer the best quality of healthcare to your child at TRCC, we have updated some of our policies regarding medication administration. Please note the following:

To prevent problems with administration of medications, your child **MUST** have a medication form completed by his/her physician for any prescription or non-prescription medications which are to be administered to your child while at camp. Medications **WILL NOT** be administered to your child unless this form is in place.

Over the counter medications will be kept in the nurse's cabin for use by the campers if needed. A list of the medications that may be available can be seen below. Please check off any medications which you **DO NOT** want administered to your child by the TRCC health staff.

- Tylenol (acetaminophen)
- Advil (ibuprophen)
- Topical Antibiotic Ointment
- Antihistamine (such as Benadryl)
- Decongestants (such as Sudaphed)
- Cough suppressant (such as Robitussin)

Please list any medication Allergies your child has:

Signature of Parent or Guardian

Tidal River Christian Camp

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY CAMP PERSONNEL

The Connecticut state law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medication or in the nurse's absence, a designated adult to administer medications. Medications must be in a pharmacy prepared container and labeled with name of child, name of drug, strength, dosage, frequency, physicians or dentist's name and date of original prescription.

PHYSICIAN'S OR DENTISTS ORDER: TYPE OR PRINT ONLY

NAME OF CHILD _____ DATE: _____

ADDRESS: _____ DATE OF BIRTH: _____

DRUG: Name, dose and method of administration _____

Condition for which drug is being administered: _____

Administered From (date) _____ to (date) _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____ If yes, DEA number: _____

Physician's or Dentist's Name: _____ (type or print)

Address: _____ Phone: (____) ____ - _____

Physician's or Dentist's

Signature: _____ Date: _____

AUTHORIZATION BY PARENT OR GUARDIAN for the administration of the above medication by TIDAL RIVER CHRISTIAN CAMP PERSONNEL:

Date: _____

TO CAMP PERSONNEL:

I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by camp personnel. I understand that I must supply the camp with the prescribed medication in the original container, dispensed and properly labeled by a physician or pharmacist and will provide no more than a fourteen day supply of said medication.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of camp.

Name: (type or print) _____

Signature: _____ Relation to Child: _____

Address: _____ Phone: (____) ____ - _____