THE MOUNTAIN WORKSHOP
AWESOME ADVENTURES
TRAILMARK EXPEDITIONS

The Mountain Workshop
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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

In order for The Mountain Workshop to administer medications, Connecticut State Statutes and Regulations **require a physician's or dentist's written order and parent or guardian's authorization** for a Mountain Workshop staff member to administer medications. Medications must be in the original container and labeled with the child's name, name of the 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 participant's departure at the end of camp.

AUTHORIZED PRESCRIBER'S ORDER (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Participant's Name ______________________ Date of Birth __________ Date ______________

Address ______________________________________ Phone (Home) ______________

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 (Print) ______________________ Phone Number (____) ______________

Prescriber's Address ______________________________ Town ______________

Prescriber's Signature ______________________________

AUTHORIZATION BY PARENT OR GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION:
I request that medication be administered to my child as described and directed above.

Today's Date ______________

Participant'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)** ______________