PROGRAM MEDICAL RELEASE INFORMATION

Requires parent/guardian signature to register. Requires physician's information and signature if applicable

**** Must be filled out completely in order to enroll in the camp program. ****

MEDICAL/BEHAVIORAL INFORMATION

If your child requires medication during camp, has an epi-pen, or inhaler, you must fill out the Medication Administration section.

Allergies____

Medical Issues/Concerns:____

Does the child have any behavioral issues and if so, what is the best way to address this:__________________________________

____

____________________________________DATE______

MEDICATION ADMINISTRATION *to be filled out only if child requires medication during camp hours, includes epi pens and inhalers.*

All medications, **both prescription and "over the counter"** (Tylenol, Advil, etc) must be brought in the original prescription container and contain only that days dosage. The prescription container must identify the following; name of the drug, the dosage, how frequently to take it and how to take it. The container must also clearly identify the pharmacy where the prescription was filled and who is the prescribing physician. All medications, both prescription and "over the counter" must be given to the designated medication supervision staff person. Parks & Recreation staff provide reminders and assistance to program attendees who need to medicate. The staff person will record and keep proper documentation. Inhalers should be kept with the participant at all times. Epi-pens will be kept by the staff and readily available. Liquid medications must be in individual packets. Participants who are taking antibiotics should have taken them for a full 24 hours before returning to the program. This is to observe that the participant is not having any adverse reactions to medication or is not contagious. Connecticut State Law and Regulations require a physician's written order, and parent or guardian authorization for Summer Camp Staff to assist participants in self-medications.

Name of Child____Date_____/______/_________DOB______/______/_________

Condition for which drug is being administered___________________________________Name of Drug_____________________

Amount of Drug (dosage)___________Time of Administration_____________Length of time during which medication shall be administered:

Dates_________To _________Relevant side effects to be observed, if any____

____ _______________________________________ ___ _________

Address **Date**

Parent/Guardian Authorization: I hereby give permission for the above participant to take this medication as prescribed. I understand that all medications must be in their original containers, must be labeled, and have specific directions for use on label. A prescription must include the prescription number, medication name, date filled, child's name, doctor's name, pharmacy and have expiration date noted.

____ ___________________________________

Date