Project Oceanology

UNDERSTANDING THE SELF ADMINISTRATION OF MEDICATION FORM

Project Oceanology chooses to have campers self-administer medications under the supervision of trained staff and in accordance with CT State Laws. **All medications are secured by Project O staff** and distributed to the camper as directed by the Physician's written order (Form: Authorization for the Self-Administration of Medication by Youth Camp Personnel). All camp staff are certified in medication administration which includes Epi-Pen as well as First Aid/CPR.

The "Authorization for the Self Administration of Medication by Youth Camp Personnel" form is needed for EVERY medication your child brings to camp.

The top half of this form is the Physician's Written Order (***Physician signature required***).

The bottom half of the form is the Parent's consent for self-administration of medication. This does not mean your child will self carry their medication. As stated above, it means your child will self administer their medication when it is distributed to your child by certified Project O staff as directed by the Physician's written order. We cannot accept medication if this form is not signed by both the Physician and the Parent.

If you have any questions about this procedure or completing the form, please contact us before submitting the form to your child's physician.

Rev 12.19

☐ This form does not apply to my camper

Authorization for the Self-Administration of Medication by Youth Camp Personnel

1 form per medication required

Project Oceanology chooses to have campers self-administer medications under the supervision of certified camp staff and in accordance with CT State Laws. ***This does not mean the camper will self carry their medication***. All medications are secured by certified camp staff and distributed to the camper as directed by the Physician's written order below. **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 PHYSICIAN'S ORDER (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child_____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child_____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 _____/_____/_____

PARENT/GUARDIAN AUTHORIZATION

- I request that medication be administered to my child as described and directed by Physician above
- I understand and authorize the above ordered medication be administered by my child under the supervision of certified Project O camp staff as directed above and in accordance with CT State Laws
- I understand and authorize the exchange of information between the Prescriber and Project Oceanology to the extent necessary to ensure the safe administration of this medication and to complete camp form requirements.

Parent/Guardian Signature: _____ Date _____/_____/_____

Parent /Guardian's Address _____ City_____ State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

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INTERNAL USE ONLY

Today's Date _____

Printed Name of Camp Staff receiving written authorization and medication _____

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