

Authorization for the Self-Administration of Medication While Attending Programs at the Madison Arts Barn

Parent/guardians requesting to be self-administered by their child while at camp shall provide the program with appropriate written authorization and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp. **AUTHORIZED PRESCRIBER'S ORDER** (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ___/___/___

Today's Date ___/___/___ Medication Name _____

Controlled Drug? Yes No /Dosage _____ Method _____

Time of Administration _____ Specific Instructions for Medication Self-Administration _____

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___

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 _____ Phone Number _____

Prescriber's Address _____ Town _____ ST _____

Prescriber's Signature _____ Date: _____

Parent/Guardian Authorization:

I request that medication be self-administered by my child as described and directed above.

Name of Camp _____ Today's Date ___/___/___

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Self-Administration of Medication _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone # _____

Signature of Parent/Guardian Authorizing Self-Administration of Medication _____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____