



WESTERN CONNECTICUT STATE UNIVERSITY

Medication Authorization

Authorized Prescribers Order (Physician, Dentist, Physicians Assistant, Advanced Practice Registered Nurse):

Child's Name _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication: _____ Controlled Substance Yes No

Dosage _____ Method _____

Administered: Breakfast Lunch Dinner Bedtime Other _____

Specific Instructions for these Medications _____

Length of time medication is being taken Start Date ____/____/____ Stop Date ____/____/____

Can the child self-administer the medication? Yes No

Side Effects for the Medication _____

Plan of Management for Side Effects _____

Food or Drug Allergies? Yes No Reactions? Yes No Interactions? Yes No

If "yes" to any of the above, please explain _____

Prescriber Name _____ Phone Number (____) ____ - ____

Prescriber's Address _____ Street City State Zip

Prescriber Signature _____ Date _____

Parent/Guardian Authorization for Administration of Medication as described and directed above:

Name _____ Relationship to Camper _____

Home Address _____ Street City State Zip

Home Phone (____) ____ - ____

Signature of Parent / Guardian for Authorization

Date