



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