Earl Mosley's Institute of the Arts
2 Merry Acres Lane, New Milford, CT 06776
860.350.6494p, 860.210.1986f, info@emiadance.org

Authorization for the SELF Administration of Medication

PAGES MUST BE COMPLETED and Signed/Dated in ALL REQUESTED PLACES
Return Signed Copies to EMIA via email (preferred), mail of fax
Completed forms may also be brought to check-in with medication.

Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. **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. Over the counter medications as well as prescription medications. ONE medication per form**

Authorized Prescriber's Order for Self-Administration of the Medication Authorized Below (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Student _____ Date of Birth____/____/____

Address of Child/Student_____Town_____State ___ Zip _____

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 _____ State ___ Zip _____

Prescriber's Signature _____ Date _____/_____/_____

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Parent/Guardian Self-Administration Authorization:

I request that the medication prescribed above be self-administered by my child/student as described and directed above under camp supervision by the camp health director.

I hereby request that the above ordered medication be self-administered by my son/daughter, under the supervision of youth camp personnel and I give permission for the exchange of information between the prescriber camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the camp with no more than a one month supply of medication (camp only)

Parent/Guardian Signature_____ Relationship_____ Date____/____/____

Parent /Guardian's Address _____Town_____State_____Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

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To Be Completed by EMIA Health Director or Assistant

Date Received _____

Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature _____