

CONNECTICUT FIELD HOCKEY CAMP, LLC  
PO BOX 728, STORRS CT 06268

**STATE PROCEDURES REGARDING MEDICATIONS:**

*Campers must surrender all medication, EVEN OVER-THE-COUNTER MEDICATION (i.e. Tylenol, Advil, etc) to our Medical Staff at check-in, to be placed in a locked medical box for the duration of the camp. Campers may self-administer medications when needed with documented parental and authorized prescriber permission. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.*

Date: \_\_\_\_\_ I hereby request that the following medication be self-administered by my daughter, \_\_\_\_\_, for the camp week of July \_\_\_\_\_, 2009.

(PLEASE PRINT CAMPERS NAME) \_\_\_\_\_

**I understand that I must supply the youth camp with the prescribed medication in its original container and properly labeled by a physician/pharmacist. Over the counter medication shall be labeled with the child's name by the Parent/Guardian(s) at check-in.**

**I understand that this medication will be destroyed if not picked up within (1) week following the end of this session of camp.**

Name of Medication: \_\_\_\_\_

Times of Administration: \_\_\_\_, \_\_\_\_, \_\_\_\_ Shall be administered from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Is this a controlled drug? \_\_\_\_\_

Authorized prescriber's or Dentist Name (PRINT): \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Authorized Prescriber or Dentist Signature \_\_\_\_\_

Parent/Guardian(s) Name (Printed): \_\_\_\_\_

Parent/Guardian(s) Signature: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Phone Number: \_\_\_\_\_