## Connecticut Department of Children and Families WILDERNESS SCHOOL – PRESCRIPTION MEDICATION AUTHOPRIZATION (PSYCHIATRIC)

DCF-2305

1/18 (Rev.)



In Connecticut, Youth Camps Parents/guardians requesting m must be in the original container School ninety-six (96) hours prio	edication administra and labeled with child	tion to their o d's name, nar	hild sh	all provide the	program	with appropri	iate written permission	and the medicat	ion(s)	before any med	dications	s may be	administe	red. Medications	
Student LAST Name:	Student FIRST Name:		DOI	B:		Address (No. and Street):				City:				Zip:	
Parent/Guardian LAST Name:	Parent/Guardian FIRST Name:		Relationship:		Address (No. and Street, if different from above):			City:		State:		Zip:			
To the parent/guardian:	I give permission that	at the medicat	tion liste	ed below be ac	dministere	d to my child/y	outh as described and	directed below							
Parent/Guardian Signature												Date			
Name of Prescribing Physician/APRN/PA:			Phone:			Address (No. and Street):			City:		State:		Zip:		
Please complete chart below,	in detail, for each p	rescribed m	edicati	on and sign	for each i	medication o	rdered:								
Medication			es of Route		Specific	Instructions	Side effects and plan for management	Allergies, reactic interactions with f drugs		Controlled Medication?	(Start	of Order / stop if icable)	Presci	Prescriber's Signature	
										☐ Yes					
										☐ No	□ No				
										☐ Yes					
										☐ No					
										☐ Yes					
										□ No					
										☐ Yes					
										□ No					
										☐ Yes					
										□ No					