

CONNECTICUT ELITE
VOLLEYBALL CAMP, LLC
PO BOX 613
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 _____.
(PLEASE PRINT CAMPERS NAME) (DATE)

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: _____

Name of Child: _____ Room #: _____ Skill Group: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

Medication Name: _____

Date: __/__/__ Time: _____ AM/PM Dosage: _____ Strength: _____ Trainer: _____

Comments: _____

