TOWN OF MONROE

PARKS & RECREATION DEPARTMENT

7 Fan Hill Road
Monroe, CT 06468
Phone: 203-452-2806
www.monroerec.org

Monroe Parks and Recreation
Wolfe Park * Masuk Pool *Lake Zoar
Webb Mountain Camping

Allergy and Medication Administration Authorization Form

**Even if your child is not on any medication this form needs to be filled out in full to let us know if there are any or no allergies.*

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)
One form per medication, please.

**If this does NOT pertain to your child please just fill out the Allergy section below (every child needs to fill out second part of form)*

Name: ____

DOB:____________________Age:______________

Medication Name ____
Controlled Drug? YES □ NO □

Dosage ______ Method ___________Time of Administration/Frequency _____________

Specific Instructions for Medication Administration (e.g., on an empty stomach, with milk, with food, etc.)
____

Specify Precautions ____

Medication Administration: Start Date:____/____/____ Stop Date: ____/____/____
Quantity Received __________

Expiration Date of Medication Received:____/____/____Special Storage Requirements ______________

Relevant Side Effects/Adverse Reactions ____
Plan of Management for Side Effects ____

Prescriber's Name ______________________________ Business telephone ( ) ___________

Prescriber's Signature _________________________________(only if medication is prescribed)

Prescriber's Address ____ City/State/Zip ________

Allergies

*Even if your child has no allergies, this form needs to be completed.

Does your child have any known allergies? YES □ NO □

If "yes" to the above, please explain

Diagnosis (at parent's discretion) ____

Parent/Guardian Authorization:

I hereby authorize that medication be administered to my child as described and directed above and in accordance with CT State Statutes and Regulations and MA 105 CMR 430.160

Name of Camp where medication administration will occur:
2025 Panthers Hoop Camp

Dates attending ___________________________

Name ____

Address ____ Town _______________

Name of Parent/Guardian Authorizing Administration of Medication

____

Relationship to participant: Mother □ Father □ Guardian/Other □

Address (if different from above)____
Phones: Home ______________Cell ________________________Work _______________

Emergency Contact Name and Telephone Number ____

Signature of Parent/ Guardian ____Date ________________

Panthers Hoop Camp