SAMPLE

Written Approval for
Administration of Medication Training for Youth Camps

_____
Name of Student

_____ _____
Address of Student (Street Address, City/Town, State, Zip Code) Phone Number of Student

The student has successfully mastered and demonstrated the required training in the methods of medication administration that included the required curriculum areas specified in Section 19a-428-6(a)(2)(A)(ii) of the Regulations of Connecticut State Agencies. In addition, the student has successfully completed training on the route(s) of administration noted below and therefore understands the indications, side effects, handling and methods of administration of such medication(s).

(Check all that apply)

- ☐ Oral, topical, and inhalant medication (valid for three years)
- ☐ Injectable medications by a premeasured commercially prepared auto-injector (valid for one year)
- ☐ Rectal medications (valid for three years)
- ☐ Injectable medications other than by a premeasured commercially prepared auto-injector (valid for three years)

Trainer Information:

_____ _____
Full Name of Physician (MD/DO);
Pharmacist (R.Ph.), Physician Assistant (PA);
Advanced Practice Registered Nurse (APRN) or
Registered Nurse (RN) License Number

_____
Signature / Title

_____ _____
Address Date of Training

_____ _____
Phone Location of Training