

OLD SAYBROOK PARKS & RECREATION
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

If your child is on medication or requires medication in the event of an emergency, parents **MUST** provide the following information:

IF CHILD WILL NEED TO TAKE MEDICATION DURING PROGRAM HOURS (prescription & non-prescription drugs) AND/OR IF CHILD REQUIRES MEDICATION IN THE EVENT OF AN EMERGENCY (EpiPen, asthma inhaler, etc.)

1. The authorized prescriber must complete the Authorized Prescriber's Order (Section1) of the "Authorization for the Administration of Medication" form attached.

THIS FORM MUST BE COMPLETED BEFORE ANY MEDICATION CAN BE ADMINISTERED

2. The parent/guardian must complete the Parent/Guardian Authorization (Section 2) of the "Authorization for the Administration of Medication" form attached.

THIS FORM MUST BE COMPLETED BEFORE ANY MEDICATION CAN BE ADMINISTERED

3. A child may only Self-Administer medication with written authorization of the Authorized Prescriber and the Parent/Guardian.

THIS FORM MUST BE COMPLETED BEFORE ANY MEDICATION CAN BE SELF-ADMINISTERED

4. Parents will be asked to provide program Staff with pre-measured dosages of the prescribed medication. Medication must be in the original container and labeled with the child's name, name of medication, directions for medication's administration and date of the prescription.

5. All unused medication will be destroyed if not picked up within one week following the end of the program.

POLICY FOR CHILDREN WITH FOOD ALLERGIES:

- The primary safeguard for a child with food allergies is for the child to consume only food/snacks that he/she bring to the program each day.
- Staff will enforce strict no food trading/sharing rules. Table surfaces will be washed clean and children will wash their hands after snack/food.

We do assume the child with an allergy has been instructed by the Parent/Guardian not to touch trade or share food with anyone else.

- The completed "Authorization for the Administration of Medication" form is **REQUIRED**. Staff who are not certified to administer Epi-pens, will use the instructions to **ASSIST THE CHILD** in an emergency if necessary.

So that the program staff may be prepared to handle an emergency situation, the form must be on file **BEFORE** your child attends.

RETURN FORM AND INFORMATION TO THE PARKS & RECREATION OFFICE - PRIOR TO THE START OF THE PROGRAM! MEDICATION CAN BE BROUGHT ON THE FIRST DAY OF THE PROGRAM.

If you have any questions, contact the Parks & Recreation Office at 860-395-3152.

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth ___/___/___ Today's Date ___/___/___

Address of Child/Student _____ Town _____

Medication Name/Generic Name of Drug _____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage _____ Method/Route _____

Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date: ___/___/___ End Date: ___/___/___

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ___/___/___

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____ Relationship _____ Date ___/___/___

Parent /Guardian's Address _____ Town _____ State _____

Home Phone # (____) _____ - _____ Work Phone # (____) _____ - _____ Cell Phone # (____) _____ - _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES NO _____
Signature _____ Date _____

Parent/Guardian authorization for self-administration: YES NO _____
Signature _____ Date _____

School nurse, if applicable, approval for self-administration: YES NO _____
Signature _____ Date _____

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

- Authorization form is complete
- Medication is in original container
- Medication is appropriately labeled
- Date on label is current

Person Accepting Medication (print name) _____ Date ____/____/____