AUTHORIZATION FOR THE ADMINSITRATION OF MEDICATIONS BY THOMPSON RECREATION PERSONNEL

You must complete this form if your child will be taking any medication (prescription or over-the counter, including epi-pen and inhaler) at Recreation Programs. Complete one form for each medication.

If a Child Day Care center, Group Day home, or Family Day Care chooses to administer medications the Connecticut State Law and regulations require an authorized prescriber's written order and parent or guardian's authorization for a nurse, director, teacher, group or family day care provider to administer medications. Medications must be in a pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, authorized prescriber's name and date of original prescription. Over the counter medication must be in original container and labeled with the child's name.

To Be Completed By Authorized Prescriber (Doctor, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of child_____ Date of Birth _____

Address _____ Date medication ordered_____

Condition for which drug is being administered during program hours _____

_____

Medication Name _____ Controlled Drug? ☐ Yes ☐ No

Dosage _____ Method_____ Time of Administration_____

Medication shall be administered Start Date_____ End Date _____

Is this medication to be self administered by child? ☐ Yes ☐ No

Relevant side effects to be observed, if any _____

Plan of management for Side Effects _____

Known Food or drug Allergies? ☐ Yes ☐ No If Yes, explain_____

Reactions to? ☐ Yes ☐ No If Yes, explain_____

Interactions With? ☐ Yes ☐ No If Yes, explain _____

Authorized Prescriber Name _____Tel _____
(type or print)

Address _____ Town/State_____

Authorized Prescriber's Signature _____ Date _____

AUTHORIZATION BY PARENT/GUARDIAN FOR ADMINISTRATION OF THE ABOVE MEDICATION:
To Be Completed By Parent/Guardian

To Thompson recreation staff: I hereby request that the above medication, ordered by the authorized prescriber for my child, _____, be administered by the Thompson Recreation staff. I understand that I must supply the Thompson Recreation staff with the prescribed medication in the original container dispensed and properly labeled by authorized prescriber or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order.

I have administered at least one dose of the above medication to my child without adverse effects. ☐ Yes ☐ No

Parent/Guardian Name_____
Please type or print

Signature_____ Relationship to Child _____

Address_____ Telephone_____