

MEDICATION AUTHORIZATION

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.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY THOMPSON RECREATION PERSONNEL

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):

Name of child _____ Date medication ordered _____

Address _____ Date of Birth _____

Condition for which drug is being administered during daycare hours _____

Name, dose, time, method of administration _____
(specific instructions as to how medication should be given)

Medication shall be administered from _____ to _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Allergies to food or drug? If YES, list _____

Does this medication have any negative interactions with food or drugs? If YES, list _____

Authorized Prescriber _____ Date _____
(type or print)

Address _____ Tel. _____

Authorized Prescriber's Signature _____

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 _____

Signature _____ Please type or print Relationship to Child _____

Address _____ Telephone _____