



## Southington-Cheshire Community YMCAs Authorization for the Administration of Medications by YMCA Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day 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. Medication must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of prescription. **If we receive an Administration of Medication form, and your child's medication is for a potentially life threatening condition (example: asthma, diabetes, food or bee allergy), the medication MUST BE RECEIVED AT CAMP/CHILDCARE BEFORE your child can attend. Your child cannot be in the program without the medication present.**

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

Name of Child/Student: \_\_\_\_\_ DOB: \_\_\_\_\_ 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 of Drug: \_\_\_\_\_ Method/Route \_\_\_\_\_

Time of Administration \_\_\_\_\_ If PRN, Frequency \_\_\_\_\_

Medication shall be administered: Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ End Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

May substitute generic drug with this active ingredient \_\_\_\_\_  No Substitutes

Allergies to food or drugs? If yes, please list: \_\_\_\_\_

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) \_\_\_\_\_

**Authorization by parent/guardian of the administration of the above medication:**

I request that the above medication, ordered by an authorized prescriber for my child be administered by a YMCA staff member appropriately trained in administering medication and/or a regulated injection medication (i.e. EpiPen). I understand that I must supply the YMCA with the medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by me with my child's name. I understand that I must give my child the first dose of this medication. **I understand that this medication will be destroyed if it is not picked up within one week of my child's last day in the program. If my child is transported by bus, I realize that this medication is not available during that time and I take full responsibility for my decision not to personally transport my child.**

- I request that medication be administered to my child/student as 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 Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

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 \_\_\_\_\_

## Southington Community YMCAs Medication Administration Record

Child's Name \_\_\_\_\_ Prescriber's Name \_\_\_\_\_  
 Medication \_\_\_\_\_ Pharmacy \_\_\_\_\_  
 Dosage \_\_\_\_\_ Prescription # \_\_\_\_\_  
 Method of Administration \_\_\_\_\_

Date	Time	Dosage	Remarks	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	

Before any medication is administered for the first time the following items must be in place:

- The authorization form is complete
- The medication is in its original safety cap container
- The medication is appropriately labeled
- The date is on the prescription. The date is current (within the expiration date)

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

This medication was returned to \_\_\_\_\_ on this date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Staff Signature: \_\_\_\_\_