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 of 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

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

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
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ 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 form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)