AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

THIS FORM MUST BE FILLED OUT IF A CHILD NEEDS TO TAKE MEDICATION DURING PROGRAM HOURS.

The Children's Museum shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at a program shall provide appropriate written authorization(s) and the medication BEFORE any medications are administered. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the medication, directions for medication's administration, prescriber's name, and the date of the prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER'S ORDER (Physician, Dentist, Physician Assistant, Advanced Practice RN)
(Prescriber's Order is REQUIRED for all medications other than non-prescription topicals)

Date: / /

Name of Child: ____ Date of Birth / /

Medication Name ____________________________________ Controlled Drug? Yes ______ No ______

Dosage ______ ______ Method ______ __________ Times of Administration: _______, _______, _______,

Specific Instructions for Medication Administration ____

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___

Is this medication to be self-administered by the child? Yes ______ No ______

Relevant Side Effects of Medication ____

Plan of Management for Side Effects : ____

Known Food/ Drug Allergies? Yes ____No ____ Reactions to? Yes ____No ____ Interactions with? Yes ___No ___

If yes to any of the above, please explain: ____

Authorized Prescriber's Name: ______________________________ Phone (___)__________________

Prescriber's Address ______________________________ Town ____________________ State _____

Authorized Prescriber's Signature: ____

PARENT/GUARDIAN AUTHORIZATION

Parent/Guardian Authorization is REQUIRED for all topical, oral, and inhalant medication applications.

It is recommended for any application i.e. sunscreen, insect repellant

I request that medication be administered to my child as described and directed above. I understand and agree to the terms indicated in the shaded box above. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Child's Name ______________________________ Name of Program ______________________________

Street Address ______________________________ Town ____________________ State _____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name __________________ Last Name __________________ Relationship to child ______________

Signature of Parent/Guardian ______________________________ Date / /

Street Address ____

City/Town ______________________________ State _____ Zip _______Phone (___) ______________

FOR PROGRAM USE: Staff who received written authorization & medication ______________________________

Title/Position ______________________________ Signature (in ink) ______________________________