



TOWN OF COVENTRY DEPARTMENT OF PARKS & RECREATION
WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER/PARENTS PERMISSION FOR
THE ADMINISTRATION OF MEDICATION

All children who require medication, especially those with special health care needs, should be able to attend child care and have their health needs addressed. This policy was developed to facilitate safe and consistent medication administration policies in accordance with the Connecticut General Statutes and Regulations of CT State Agencies for child care centers, camps, group and family day care homes. To accommodate this need, selected staff members who are trained according to regulation requirements, will follow all procedures as mandated by these regulations.

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

Name of Child: Date of Birth: Today's Date:

Condition for which medication is being administered during program hours:

Medication Name: Date of Order: Controlled Drug? Yes No

Dose: Route: Time:

Medication Administration Start Date: Medication Administration End Date:

Relevant Side Effects of Medication:

Plan of Management of Side Effects:

Allergies to food or medications: Yes No If Yes, please list:

Interaction of Medication with food:

Name of Licensed Prescriber: Phone #:

Address: Fax #:

Licensed Prescriber's Signature: Date:

Parent/Guardian Authorization:

I hereby request that the above medication, ordered by the physician/dentist/advanced practice registered nurse/physician assistant for my child, be administered by certified, trained staff members at Coventry Parks & Recreation. With the exception of emergency medication, I confirm I have given at least one dose of the medication without evidence of side effects or adverse reactions. I understand that I must supply the program with the prescribed medication in the original container dispensed and properly labeled by the physician 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 authorize the program to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: Yes No

Signature of Parent/Guardian Printed Name of Parent/Guardian

Address Phone #

Relationship to Child: Mother Father Guardian/Other; Explain:

Self Administration of Medication Authorization/Approval (If Applicable):

Self-Administration of medication may be authorized b the prescriber and parent/guardian.

Prescriber's authorization for self-administration: Yes No Signature Date

Parent/Guardian's authorization for self-administration: Yes No Signature Date

Staff Member Certified in the Administration of Medication receiving & reviewing this order:

Name Signature Date