SIMSBURY PARKS & RECREATION DEPARTMENT

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Parents/Guardians requesting medication administration to their child shall provide the program with the appropriate written authorizations(s) and the medication before any medications are administered. All medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.

1. AUTHORIZED PRESCRIBER'S ORDER (Physician, Dentist, Optometrist, Physician Assistant, Advance Practice Registered Nurse) Name of Child_____

Date of Birth_____/_____/_____ **Todays Date**_____/_____/_____

Address of Child_____

Town_____**State**_____**Zip Code**_____

Medication Name/Generic Name of Drug_____

Controlled Drug? Yes_____ **No**_____

Condition for which drug is being administered_____

_____

Specific Instructions for Medication Administration_____

_____

_____

_____

Dosage_____ **Method/Route**_____

Time of Administration_____**If PRN, frequency**_____

Medication shall be administered: Start Date:_____/_____/_____

End Date:_____/_____/_____

Relevant Side Effects of Medication_____

None Expected_____

Explain any allergies, reactions to/negative interactions with food or drugs_____

Plan of Management for Side Effects_____

Prescriber's Name/Title_____

Phone Number ( )_____-_____

Prescriber's Address_____**Town**_____**State**_____

Zip Code_____

Prescriber's Signature_____

Date:_____/_____/_____

2. PARENT/GUARDIAN AUTHORIZATION

_____ I request that medication be administered to my child as described and directed above.

_____ I hereby request that the above medication be administered by Simsbury Parks & Recreation personnel and I give permission for the exchange of information between the Prescriber and Parks & Recreation personnel as necessary to ensure the safe administration of this medication.

_____ I have administered at least one dose of the medication with the exception of emergency medications to my child without adverse effects.

Parent/Guardian Signature_____
Relationship_____ Date_____/_____/_____
Parent/Guardian's Address_____
Town_____State_____
Home Phone: ( )_____-_____
Work Phone : ( )_____-_____
Cell Phone: ( )_____-_____

3. SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian.

Prescriber's authorization for self-administration: Yes_____ No_____

_____
Signature and Date

Parent/Guardian authorization for self-administration: Yes_____ No_____

_____
Signature and Date

DEPT. USE ONLY

Today's Date _____/_____/_____

Printed Name of Individual Receiving Written Authorization and Medication

_____

Title/Position_____

Signature_____