TOWN OF NEWINGTON

131 Cedar Street Newington, Connecticut 06111

Parks & Recreation Department

Authorization for the Administration of Medication by Newington Parks and Recreation Staff

The Newington Parks & Recreation Department requires a physician's written order and parent/guardian authorization for Newington Parks and Recreation staff to administer emergency medications. Parents/guardians requesting medication administration to their child by Newington Parks and Recreation staff shall provide the Parks and Recreation office with appropriate written authorization(s) and the medication before the child begins attending the program and any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order. **Both prescription and "over the counter" medications require a written doctor's order and a parent/guardian signature.**

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, APRN)

Name of Child _____ Date of Birth ___/___/___ Today's Date ___/___/___

Medication Name _____

Prescribed dosage _____ Method _____

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 or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "YES" to any of the above, please explain _____

Prescriber's Name _____ Phone (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and I attest that **I have administered at least one dose of medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Program _____ Today's Date ___/___/___

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____

Address _____ Town _____ Phone (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Program Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

5/10/2017

Medication Administration Record (MAR)

Name of Child/Student _____ **Date of Birth** ____/____/____

Pharmacy Name _____ **Prescription Number** _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication 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	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** ____/____/____