BOYS & GIRLS CLUB
OF THE LOWER NAUGATUCK VALLEY

Authorization for the Administration of Medication

This Authorization for the Administration of Medication form is required for any child who needs to self administer any medications, such as an epi pen or inhaler. Though our staff is certified in first aid and CPR, we do not administer medications of any kind. We will, however, make reasonable accommodations for a parent or guardian to come administer any medication that may not be self administered by your child.

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

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

Medication Name _____ Controlled Drug? ❑Yes ❑No

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for 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 Number ( ) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization

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

Organization: Boys & Girls Club of the Lower Naugatuck Valley Today's Date _____

Child's Name _____ Address _____ Town _____

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

First Name _____ Last Name _____

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)** _____

BOYS & GIRLS CLUB
OF THE LOWER NAUGATUCK VALLEY

Medication Administration Record (MAR)

Name of Child ______________________ 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	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

❑ Authorization form is complete **❑ Medication is appropriately labeled**
❑ Medication is in original container **❑ Date on label is current**
Person Accepting Medication (print name) ______________________ **Date** ___/___/___

*** Medication Authorization Form must be used as either a two-sided document or attach first and second page.**

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Individual Plan of Care for a Child

With Special Health Care Needs or Disabilities

Child's Name:_____ Date of Birth_____/_____/_____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s): Date Signed:

_____ ____/_____/_____

_____ ____/_____/_____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.

Signature of the staff responsible for ____(name of child)

Printed Name Signature Date Signed	Printed Name Signature Date Signed