Town Of Stonington
Department of Human Services

166 South Broad Street Pawcatuck, Connecticut 06379

Recreation ◇ Senior Services ◇ Social Services ◇ Youth & Family Services

Youth Programming Medication Self-Administration Policy

Connecticut State Law and Regulations (19a-79-9) requires a physician's or a dentist's written order and the parent guardian's written authorization in order for medication (including non-prescription medications) to be given. It is the policy of the Department to allow youth program participants to self-medicate according to the orders of their own physicians and in accordance with the below guidelines:

- A copy of the completed Medication Self-Administration form on file.
- Prescribed and over-the-counter medications must be brought in their original container. The prescription container must identify the following: name of the drug, dosage and frequency and how the drug is administered. The container must also clearly identify the pharmacy where the prescription was filled and who the child's prescribing physician is. All medications, both prescription and over-the-counter must be given to Human Services' staff.
- Staff will provide reminders and assistance to program attendees who need to self medicate; i.e. staff will remind attendees at what time the medication is due and staff will assist in opening safety proof containers, and help attendee obtain the correct number of pills or tablets needed.
- Program staff will observe the attendee self-administer their medication and check to be certain that it was swallowed, inhaled, etc.
- Supervising staff will keep proper documentation verifying that the medication was taken.

Phone: (860) 535-5015 Fax: (860) 599-8290

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Authorization to Assist Program Participants in Self-Medication

Connecticut State Law and Regulations require a physician's written order and parent or guardian authorization for Human Services' staff to assist children in self-medications, both prescription and over-the-counter require a written doctor's order and a parent/guardian signature.

PHYSICIAN'S ORDER

Name:_____ Date:_____

Address:_____ Date of Birth:_____

Phone:_____

Condition for which drug is being administered:

Name of Drug: _____

Dosage Amount: _____

Side effects to be observed, if any:

Time at which medication shall be administered_____

.

_____**MD**
Signature

_____
Address

I hereby give permission for my child_____to take the medication(s) listed above.

I understand that all medications must be in their original containers, must be labeled, and have specific directions for use on label. A prescription must include the prescription number, medication name, date filled, child's name, doctor's name, pharmacy and have expiration date noted.

I hereby request that Human Services' Staff supervise and assist my child in self-medication administration as ordered by the above physician.

_____ _____
Signature of Parent or Guardian **Date**

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