

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY NGW PERSONNEL

If a workshop chooses to administer medications, State Law and Regulations require a physician's or dentists written order and parent/guardian's authorization for a nurse, first aider, the director, or alternate director to administer medications. Medications must be pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name, and the date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN OR DENTIST ORDER: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Condition for which the drug is being administered during NGW hours: \_\_\_\_\_

Medication: Name \_\_\_\_\_ Dose \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_ yes \_\_\_\_\_ no

Method of Administration \_\_\_\_\_ Times of Administration \_\_\_\_\_

Relevant Side effects to be observed, if any \_\_\_\_\_

Plan for management of side effects \_\_\_\_\_

Allergies to food or medications? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please list \_\_\_\_\_

Physician/Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Physician/Dentist Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OR MEDICATION

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

To nurse, first aider, director, alternate director:

I hereby request that the above medication, ordered by the physician/dentist for my child \_\_\_\_\_, be administered by the nurse, first aider, director, or alternate director.

I understand that I must supply the NGW with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container and labeled with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following student's departure from NGW.

Name of Parent/Guardian \_\_\_\_\_ Signature \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_