Boys & Girls Clubs of Greater Manchester

Medication Policy & Information

You, as a parent, requesting our staff to administer medication to your child, need to know the following:

1. Although our staff meet requirements for first aid care, these requirements do not include medication-dispensing procedures.

2. Our normal procedure is for our staff to call your child to an agreed upon location at the requested medication time via our P.A. system or by roll call.

3. In some instances, children do not hear or respond to this announcement resulting in medication being given late or being missed entirely.

4. We wish to work with you with respect to your child's needs, but ask you to understand that there may be instances of late or missed medication.

5. It is our policy that the child accepts full responsibility for reporting to the agreed upon location at the prescribed time to receive his/her medication from staff.

6. We will not administer any medication without written authorization by your child's physician on our form.

7. Our staff **will not** administer injections for diabetes, bee stings, etc. Any child who attends the School Year or Summer Program with a medical condition, which requires or may require an injection, must be able to self-administer the medication. In the event the child is unable to administer the injection, a trained staff member will do so for him/her.

8. Children who self-administer medication by injection must have his/her kits on his/her person at all times while under our care.

9. Children with asthma who use an inhaler must be able to self administer and must carry their inhaler on his/her person at all times while under our care.

10. Due to recent changes in the state of NH statutes regarding day camps and youth who self administer injections or use inhalers for asthma, the attached forms must be completed in their entirety before the child is allowed to attend. **We will accept no other completed form other than the attached.**

I, _____ have read the above information regarding the medication
Parent/Guardian Name

dispensed by the Boys & Girls Clubs of Greater Manchester staff and understand the procedures and policies with respect to medication.

Parent/Guardian Signature:_____

Date: _____ Child's First and Last Name: _____

Boys & Girls Clubs of Greater Manchester

Medication Permission & Physician Order Form

(all medications other than inhalers and injections)

Child's Full Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Medication: _____

Date Ordered: _____

Dosage: _____

Route: _____

Time of Administration: _____

Special Instructions (if any): _____

_____

_____

Prescribed By (Print Dr.'s Name): _____

Physician's Signature: _____

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PARENT PERMISSION

I hereby authorize the designated staff to administer the above-prescribed medication according to the directions included. In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, the Boys & Girls Clubs of Greater Manchester and/or any employee thereof for any death or injury resulting from the administration or assistance in the administration of the medication described above. I also understand that the Boys & Girls Clubs of Greater Manchester staff will not administer injections.

Signature of Parent/Guardian: _____

Date: _____ Emergency Phone Number: _____

Boys & Girls Clubs of Greater Manchester

Medication Permission & Physician Order Form

(inhalers and epinephrine auto injectors)

Child's Full Name: _____ Date of Birth: _____

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Information in the box below **must be filled out by Physician.** (RSA 485-A:25-b, RSA 485-A:25-f)

Medication: _____

Date Ordered: _____

Dosage: _____

Route: _____

Time of Administration: _____

Specific Recommendations for Administration:_____

Special side effects, contradictions, and adverse reactions to be observed: _____

Special side effects, contradictions, and adverse reactions to other children if taken:_____

Diagnosis: _____

Other medical conditions requiring medications:_____

The child named above has the knowledge and skills to safely possess and use the below medication(s).

Physician must initial: _____ Asthma inhaler _____ Epinephrine auto injector

Physician's Business Number: _____

Physician's Emergency Number: _____

Prescribed By (Print Dr.'s Name): _____

Physician's Signature: _____ Date: _____

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PARENT PERMISSION

I hereby authorize my child to self-administer the above-prescribed medication according to the directions included. In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, the Boys & Girls Clubs of Greater Manchester and/or any employee thereof for any death or injury resulting from the administration of the medication described above. I also understand that the Boys & Girls Clubs of Greater Manchester staff will not administer injections.

Signature of Parent/Guardian: _____

Date: _____ Emergency Phone Number:_____