

RADD

Recreational Activities for the Developmentally Disabled

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POLICY AND PROCEDURE FOR THE ADMINISTRATION OF MEDICATION

Prescription Medication and Non-prescription Medications:

Prescription medication can only be administered by approved personnel with written consent of BOTH the parent/guardian and a qualified prescriber. Non-prescription medication (i.e. pain reliever, over the counter medicine, sunscreen, bug spray ...) can only be administered by approved personnel with written consent of the parent/guardian. Written instructions must be given on the form found on the reverse side of this sheet. All consent forms must be renewed each year or when the prescription changes. Forms are available to the parent/guardian at the Cerebral Palsy Agency's office. Completed forms are kept on file in the medication locked box and at the office.

Labeling, Storage and Transport of Medication to Camp

The parent/guardian provides prescription medication in a properly labeled pharmacy container. The label must have the following information: (baggies or other unsafe containers will not be accepted)

- Child's full name
- Name and current dosage of medication
- Frequency of administration
- Prescriber's name

The parent/guardian provides non-prescription medications (including bug spray and sunscreen) in the original manufacturer's container with the following information clearly written on the container: (baggies or other unsafe containers will not be accepted)

- Child's full name
- Name and dosage of medication
- Frequency of administration

Medication administered by camp personnel is kept in a locked box.

The parent/guardian must bring medication(s) to the Cerebral Palsy Agency or camper orientation. Any other arrangements need approval from the Program Director or Executive Director

Unused Medication

At the end of the camp season, parents/guardians will be reminded to come to the Cerebral Palsy Agency office to get any unused medication. Medication not claimed within one week after the end of the camp season will be destroyed.

Please direct any questions regarding administration of medication to the Program Director or the CPA Executive Director @ 262-633-0291.



MEDICATION REQUEST

Participant: _____ Date of Birth ___/___/___ Age: _____

Participant's Address: _____ Daytime Phone: _____ - _____

PARENT / GUARDIAN AUTHORIZATION

I, the parent/guardian of the above named participant, request the medication(s) listed below be given during the respite program. I will notify the Cerebral Palsy Agency in writing if there is a change or cancellation of the medication. I have read and understand the policy information on the back of this form. The Cerebral Palsy Agency has my permission to contact the prescriber about this medication. I authorize release of this information to appropriate Respite personnel.

| Name of Medication | Dose | Time(s) to Administer |
|--------------------|------|-----------------------|
| | | |
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| | | |
| | | |
| | | |
| | | |

Parent/Guardian Signature: _____ Date: _____

PRESCRIBER AUTHORIZATION

I authorize the administration of the following medication(s) to the camper named above. I agree to be contacted by the Cerebral Palsy Agency of Racine County, Inc. as needed regarding the medication.

| Name of Medication | Dose | Time(s) to Administer |
|--------------------|------|-----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Side effects or contraindications: _____

If PRN, indications for use: _____

If PRN, actions after administration (if needed) _____

DISCONTINUING A PREVIOUSLY PRESCRIBED MEDICATION – *Complete if applicable*

Discontinue use of the medication listed below:

| Name of Medication | Dose | Time(s) to Administer |
|--------------------|------|-----------------------|
| | | |

Date
Signature of Prescriber
Prescriber's Name (Printed)