CONFIDENTIAL

CTY Medication Update Form

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This form must be fully completed in order for CTY staff members to administer the required medication. A new form must be submitted each time there is a change in dosage or time of administration. All medications must be in their original containers. Prescriptions must be labeled by the pharmacist or prescriber. Nonprescription medication must be in the original container with instructions for use. Nonprescription medication includes vitamins, supplements, enzymes (Lactaid), homeopathic, and herbal medications. All medications must be provided to CTY health staff on opening day.

Student Name: _____ CTY ID:_____Date of Birth:_____

Medication Name: _____ Dosage:_____ Route:_____

Condition for which medication is being administered: _____

Is this an emergency-use medication (e.g., rescue inhaler, insulin, epinephrine auto-injector)? ☐ Yes ☐ No
(Both parent/guardian and prescriber must authorize self-carry of emergency-use medication.)

Known Side Effects Specific to Child: _____ ☐ Check if no known side effects

If As Needed (PRN): Frequency: _____ For what symptoms: _____

Medication shall be administered from: _____ to: _____ (Not to exceed 1 year)

Medication shall be administered at ☐ Breakfast ☐ Lunch ☐ 3 PM ☐ Dinner ☐ Bedtime **OR** ☐ As needed (PRN)

Medication shall be administered ☐ Daily **OR** ☐ Every other day starting: _____ **OR** ☐ Weekly on _____

Prescriber's Authorization

I have reviewed the above information and authorize the medication to be administered as indicated above. The child may self-carry emergency-use medication if indicated below and with parent authorization. CTY staff are not required to permit self-carry of the medication.

For emergency use medication only: The student may self-carry this emergency use medication. ..... ☐ Yes ☐ No

Prescriber's Signature (parent cannot sign here): _____ Date:_____

Prescriber's Name and Title _____ Phone: _____ Fax:_____

Address: _____

Parent/Guardian Authorization

I request the CTY Summer Programs staff to administer the medication as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize CTY staff to communicate with the authorized prescriber as allowed by HIPAA.

For emergency-use medications only (e.g., rescue inhalers, insulin, epinephrine auto-injectors): CTY staff are not required to permit self-carry of the medication. Both parent/guardian and prescriber must authorize self-carry of an emergency use medication. **I consent for the student to self-carry a dose of this emergency-use medication: ☐ Yes ☐ No**

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____