Recreational Activities for the Developmentally Disabled

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RADD MEDICATION ADMINISTRATION POLICIES AND PROCEDURES

1. Prescription and over-the-counter medication can only be administered by the Program or Executive Director, with written consent of the parent/guardian through your signature on this form.
2. This consent form must be renewed each year, or updated in the event of any medication changes.
3. The parent/guardian must bring both prescription and over-the-counter medication to the program site. No medication can travel with the client. Please do not leave any medication in luggage or backpacks. Any other arrangements must be made with the Executive Director.
4. All medications must come in the original pharmacy container or manufacturer container if it is an over-the-counter medication. Baggies or any other unsafe container will not be accepted.
5. Please supply enough medication to cover the length of the program or event. Unused medication will be returned the day of departure, or will be available for pick up at the office for a one week time period.

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

PRESCRIPTION MEDICATIONS – List all medications to be administered during program hours. Attach a list if additional space is needed. Please write clearly, so accurate information can be recorded.

Medication name	Dosage	Time(s)	Purpose

OVER THE COUNTER (OTC) MEDICATION – Check all that may need to be administered during program hours. All over-the-counter medication must be supplied by parent/guardian and labeled with client name and frequency of administration.

OTC Medication	Yes	No	OTC Medication	Yes	No
Sunscreen			Antacid		
Bug spray			Sleep Aid		
Pain Reliever			Vitamin(s)		
Other:			Other:		

METHOD OF ADMINISTRATION – If medication is taken with anything other than water, parent/guardian must supply.
❑ Crushed ❑ Whole ❑ G-tube ❑ w/Water ❑ w/Applesauce ❑ w/Pudding ❑ Other: _____

I, the parent/guardian of the above named client, give permission for the medications listed above to be given at program events. I will notify the Cerebral Palsy Agency (RADD) in writing if there are any changes or cancellations of medication. I will comply with all RADD policies and procedures regarding medication administration.

Parent/Guardian signature: _____ **Date:** ___ / ___ / ___