HighHopes
Therapeutic Riding
HORSES AND HUMANS
IMPROVING LIVES

Administration of Medication Policy

In accordance with the department of public health of the state of Connecticut, High Hopes Therapeutic Riding Inc. has a written policy regarding the administration of medication. This policy covers not only prescribed medications that need to be taken during camp hours, but medicated gums, patches, inhalants, creams or lotions to include sunscreen and bug repellent. Please be sure to apply sunscreen and bug repellent before your arrival at camp.

This policy states that medications may be taken by campers and or volunteers only after:

1. The camp forms for the administration of medication, which includes the doctor's written order, had been completely filled out;
2. The medication form is signed by the camper's physician/dentist;
3. The medication from is signed by a parent or guardian;
4. The form is on file at High Hopes, one form for each medication ordered;
5. The written order is valid for the current camp session only.

Permission forms for the administration of medications may be obtained from the Camp Director at High Hopes.

Medication may be brought to camp by an adult and must be in the original container, labeled from the pharmacy, including the following:

1. Name of the camper and or volunteer;
2. Name and strength of the medication, including any measuring devises necessary;
3. Name of the prescribing physician;
4. Directions for the administration of the medication;
5. The date of the original prescription.

Over the counter medication must be in the original container and labeled with the camper's name.

In the case of antibiotics High Hopes requires that the camper or volunteer has been on the prescribed medication for at least 24 hours, prior to the arrival at camp.

Medication will be returned at the end of the camp session to an authorized adult accompanying the camper on the last day of camp.

Thank you for your cooperation and assistance in complying with the above state requirements in advance. If you have any questions or concerns, please call me at 860-434-1974, Ext. 115. See you soon!

Sincerely,

Jenn

Jenn Dube
Program Coordinator

WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER/PARENT'S PERMISSION

If High Hopes Therapeutic Riding Inc. chooses to administer medications to children the state requires compliance with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/ guardians requesting medication administration to their child shall provide High Hopes with appropriate written authorization(s) and the medication before any medications are administered by High Hopes. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

1. **Name of child**: _____ Date of Birth: _____

Address: _____

Condition for which **medication** is being administered during High Hopes Therapeutic Riding Inc. hours:

_____

2. **Medication**: _____ Date of Order: _____

3. **Dose:** _____ 4. **Route:** _____ 5. **Time:** _____

Medication shall be administered from (date): _____ to (date) _____

Side effects to be observed, if any _____ ( ) see package insert

Plan for management of side affects ( ) call parent ( ) call health care provider ( ) other: _____

Is this controlled medication? _____ Allergies to food or medications? If yes, list: _____

Interaction of medication to food: _____

Name of Licensed Prescriber: _____ Telephone: _____

Address: _____Name of Licensed Prescriber signature: _____

Authorization by Parent/Guardian for the administration of the above medication: Date: _____

I hereby request that the above medication, ordered by the physician/dentist/advanced practice registered nurse for my child _____, be administered by High Hopes Therapeutic Riding Inc. *With the exception of emergency medication, I confirm I have given at least one dose of the medication without evidence of side effects or adverse reactions.* I understand that I must supply High Hopes Therapeutic Riding Inc. 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 labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order.

I authorize High Hopes Therapeutic Riding Inc. to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: ( ) YES ( ) NO

Name of **Parent/Guardian** (print)**:** _____Signature: _____

Address: _____

Relationship to Child: _____Telephone: _____

Signature of Child Care Provider Certified in Medication Administration receiving and reviewing this form:

_____

For Controlled substances, child care and parent must fill out following: Amount/Quantity Received:
Child Care Provider signature/date: