



# Summer@Taft

## Prescription Medication Program

**Medication Authorization form:** Please complete a separate medication authorization form for each prescription medication your child will be taking while at Summer@Taft. Each form must be filled out completely and signed by both parent and prescriber, then uploaded to the student's prescription center on Magnus. Please note: **per state regulations, all medications must be prescribed by a US-based prescriber and delivered in original packaging.**

**Prescription Medications:** Please have your prescriber send any prescriptions to:

Health Complex Pharmacy  
55 Deforest St. Watertown, CT 06795  
Phone (860) 274-8816, Fax (860) 945-1728

Health Complex blister packages medications and delivers daily to Taft.

**Controlled Substances:** Stimulants (like Adderall and Ritalin) and narcotics are federally and state regulated and therefore have strict administration and storage guidelines. A reminder that **Taft does not accept controlled substances in bottles.** All controlled substances must be blister packed and delivered from Health Complex pharmacy unless you have made arrangements for an alternate pharmacy in advance.

**Epinephrine auto injectors:** Ideally students will bring two epi-pens or Auvi-Q injectors to campus, one for the Health Center and one to keep in your possession at all times. Please stop by the health center on arrival day to drop off epi-pens.

**Inhalers:** Inhalers should be kept with students. The health center can store spare inhalers if requested.

**Oral Contraceptives:** OCPs must be checked in at the Health Center. Students will have the option to either stamp and take OCPs to their rooms or to take them in the health center.

**Over the counter meds:** Tylenol, Ibuprofen, non-prescription vitamins, and OTC allergy meds are allowed in student rooms. If you have a prescription for an OTC, please stop by the Health Center to get it stamped before taking it to your room.



# Taft

## **Taft Medication Authorization Form**

*(This section to be completed and signed by parent / guardian)*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Parent / Guardian Name: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Physician / APRN / PA Medication Authorization**

*(This section to be completed and signed by the prescriber)*

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Administration Time / Guidelines: \_\_\_\_\_

Is this medication "as needed"? YES \_\_\_\_\_ NO \_\_\_\_\_

Please list any student allergies: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Practice: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**Prescriptions may be mailed or e-scribed to Health Complex Pharmacy:**

**Address: 55 Deforest St., Watertown, CT 06795 Phone (860) 274-8816**

**Controlled substances MUST be blister packaged and delivered by Health Complex Pharmacy.**