

**STATE OF CONNECTICUT**  
**DEPARTMENT OF CHILDREN AND FAMILIES**  
**WILDERNESS SCHOOL**

**V. Prescription Medications Authorization**

Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Doctor's Orders: Prescription Medications**

**A. Prescription Medications Policy:**

All prescription medications must be accompanied by a written Doctor's order on the Physician's Medical Examination form. Students must be considered appropriate for self-administration of medications and must have Doctor's approval for this.

All medications must arrive at the Wilderness School in original prescription containers and have a current prescription label attached. Medications must be delivered to the Wilderness School ninety-six (96) hours prior to the course start.

Applicants who have begun or discontinued psychiatric medication are required to wait at least twenty-one (21) days prior to participation in the 20-Day, 5-Day or Alumni Expedition unless Doctor's orders indicate otherwise.

Students who require medication needing refrigeration or delivery via a nebulizer are restricted from attending any Wilderness School course where activities may occur in a remote (non-electric) setting. Restrictions also include any specialized equipment that requires waterproof packaging or which may not reasonably be carried in a backpack without risk of damage.

**B. Doctor's Orders Prescription Medications:** Please indicate all prescription medications for which the applicant is approved to receive under Doctor's Orders. All prescription medications are to be self-administered and are to remain under the supervision of Wilderness School Instructors, with the exception of Epi-Pen injectors, which may be administered by program staff as per Doctor's Orders. Applicants with diagnoses of asthma are required to bring all prescribed inhalers as well as one unused rescue inhaler for each prescription.

Please complete in detail for each medication that is prescribed:

Medication	Dosage and Frequency	Route	Side effects / contraindications	Start & Stop/Special Considerations	Reason for medication	Controlled Medication
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no
						<input type="checkbox"/> yes <input type="checkbox"/> no

_____ Signature of Prescribing Physician	_____ Date
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NAME, ADDRESS AND PHONE NUMBER OF EXAMINING PHYSICIAN (Please print or stamp):