Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply 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 the program with appropriate written authorization(s) and the medication before any medications are administered. 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): _____ Date of Birth / / Today's Date / / Name of Child/Student Address of Child/Student ______ Town Condition for which drug is being administered: ___ Dosage ____Method /Route____ Time of Administration ____ Start Date ___/ _ / __ End Date ___/ __/ Specific Instructions for Medication Administration _____Method/Route_ Time of Administration ____ _____ If PRN, frequency_____ Medication shall be administered: Start Date: ____/___ End Date: ___/___/ Relevant Side Effects of Medication ___ ☐ None Expected Explain any allergies, reaction to/negative interaction with food or drugs Plan of Management for Side Effects Prescriber's Name/Title ______ Phone Number (____) ____ Prescriber's Address ______Town _____Town Prescriber's Signature ___ School Nurse Signature (if applicable) Parent/Guardian Authorization: ☐ I request that medication be administered to my child/student as described and directed above ☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.) ☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only) Parent/Guardian Signature___ Relationship ________State______ Parent /Guardian's Address _____ Home Phone # (____) ____ Work Phone # (____) ____ Cell Phone # (____) ____ SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student. Prescriber's authorization for self-administration:

YES NO NO Date Parent/Guardian authorization for self-administration: YES NO Date School nurse, if applicable, approval for self-administration:

YES
NO ___ Date Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication ____ Signature (in ink) Title/Position

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)