Authorization for the Administration of Prescription 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 medication 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)

A SEPARATE FORM MUST BE USED FOR EACH MEDICATION AND A NEW FORM IS REQUIRED WHEN DOSAGE CHANGES.

Name of Child/Student _____ Date of Birth _____/_____/_____ Today's Date: _____/_____/_____

Address of Child/Student

_____

Medication Name/Generic Name of Drug _____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Dosage _____ Method/Route _____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medical Administration _____

Dosage _____ 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 _____

Prescriber's Signature _____ Date _____/_____/_____

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, school health aide, 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 _____ Date _____/_____/_____

Parent/Guardian 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/school health aide (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/guardian or eligible student.

Prescriber's authorization for self-administration ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration ☐ YES ☐ NO _____
Signature Date

School Nurse/Health Aide, if applicable, approval for self-administration ☐ YES ☐ NO _____
Signature Date

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

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).