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):

<table>
<thead>
<tr>
<th>Name of Child/Student</th>
<th>Date of Birth</th>
<th>Today’s Date</th>
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Address of Child/Student

Medication Name/Generic Name of Drug

Controlled Drug? □ YES □ NO

Condition for which drug is being administered:

Specific Instructions for Medication 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 Town

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, 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 with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature Relationship Date _____/_____/_____

Parent /Guardian’s Address Town State

Home Phone # (____) ______-________ Work Phone # (____) ______-________ Cell Phone # (____) ______-________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Prescriber’s authorization for self-administration: □ YES □ NO

Signature Date

Parent/Guardian authorization for self-administration: □ YES □ NO

Signature Date

School nurse, if applicable, approval for self-administration: □ YES □ NO

Signature Date

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