

**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):**

Name of Child/Student \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Address of Child/Student \_\_\_\_\_ Town \_\_\_\_\_

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 to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Parent /Guardian's Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL**

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

- 1. Student to self-administer medication specified on this form: \_\_\_\_\_ YES \_\_\_\_\_ NO
- 2. Student to possess medication specified on this form: \_\_\_\_\_ YES \_\_\_\_\_ NO

Prescriber's Authorization and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Authorization and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School nurse (RN) Approval of self-administration (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Individual Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position/ \_\_\_\_\_ Date: \_\_\_\_\_