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

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family 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 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 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

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 _____
Signature Date

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

School nurse, if applicable, approval for self-administration: YES NO _____
Signature Date

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Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____
Title/Position _____ Signature (in ink or electronic) _____
Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)