

## 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: \_\_\_\_\_

Dosage \_\_\_\_ Method /Route \_\_\_\_ Time of Administration \_\_\_\_ Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

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.)**

## Medication Administration Record (MAR)

Name of Child/Student \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Pharmacy Name \_\_\_\_\_ Prescription Number \_\_\_\_\_

Medication Order \_\_\_\_\_

| Date | Time | Dosage | Remarks | Was This Medication Self Administered?                   | Signature of Person Observing or Administering Medication |
|------|------|--------|---------|----------------------------------------------------------|-----------------------------------------------------------|
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |
|      |      |        |         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |

\*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete

☐ Medication is appropriately labeled

☐ Medication is in original container

☐ Date on label is current

Person Accepting Medication (print name) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_