

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? Yes No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

Medication Administration Record (MAR)

Name of Child _____ 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	
				<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.

- | | |
|--|--|
| <input type="checkbox"/> Authorization form is complete | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current |

Person Accepting Medication (print name) _____ Date ____/____/____