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 _____ Date
Signature

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

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

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

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

LIFE THREATENING ALLERGY TREATMENT PLAN AND PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212a require a written medication order of an authorized prescriber and parent/guardian written authorization for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medications.

Student's Name :_____ Date of Birth:_____
Address:_____ Home Phone:_____
Physician/Allergist's Name:_____
ASTHMA ( )Yes* ( )No *higher risk for severe reaction

ALLERGY TO: Be Specific: ( ) Food_____ ( ) Latex_____
( ) Insect Sting_____ ( ) Other_____
( ) Medication_____

****SYMPTOMS OF ANAPHYLAXIS: chest tightness; cough; shortness of breath ;wheezing ; tightness in throat; difficulty swallowing; hoarseness; swelling of lips, tongue, throat; itchy mouth; itchy skin; hives or swelling; stomach cramps; vomiting; diarrhea; dizziness or faintness**

TREATMENT: if student thinks he/she has ingested the above named food:

____Observe student for symptoms of anaphylaxis** X 2 hrs.
____Administer epinephrine **before** symptoms occur, IM ( )Epipen Jr. 0.15 mg. ( ) Epipen-adult 0.3 mg.
____Administer epinephrine **if** symptoms occur, IM ( ) Epipen Jr. 0.15 mg. ( ) Epipen-adult 0.3 mg.
____Administer Benadryl_____ or Atarax_____ ( ) Swish & Swallow?
____Administer:_____
____Call 911, transport to ER for evaluation, treatment and observation *Ask for a paramedic

Is this a controlled drug? ( )Yes ( )No Time of administration:_____
Relevant side effects to be observed, if any: _____

This medication must accompany child on a field trip.

Physician's authorization for student to carry/self administer: ( ) Yes ( ) No Signature: _____ Date:_____
Parent's authorization for student to carry/self administer: ( ) Yes ( ) No Signature: _____ Date:_____
School nurse approval (if applicable) for student to self carry/self administer: ( ) Yes ( ) No Signature:_____ Date:_____

Medication shall be administered from _____ *to* _____. *Physician's Stamp*

Physician/Allergist signature_____ Phone:_____
Address:_____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

EMERGENCY CONTACTS:

Name/Relationship	Phone Number(s)	
a._____	1._____	2._____
b._____	1._____	2._____
c._____	1._____	2._____

I hereby request that the above medication and treatment plan, as ordered by the physician/allergist be carried out by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by the pharmacist.
I understand that this medication will be destroyed if not picked up within one week following termination of the order or one week beyond the close of school.
I understand that this medication is only available in the nurse's office during school hours. Parent/Guardian must contact school nurse to make arrangements for after school activities.
I give permission for the release and exchange of information on this form between the school nurse and the prescriber to ensure safe administration of the medication.

Parent/Guardian Signature:_____ Date:_____
Address:_____
Phone: (home)_____ (work)_____ (cell)_____

School Nurse/Principal/Authorized Teacher Signature: _____ Date:_____