AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION by CHILD CARE PERSONNEL

Parents/guardians requesting medication administration to their child shall provide 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: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____
Address of Child: _____Town: _____

Medication Name/Generic Name of Drug: _____ Controlled Drug? ___YES ___NO
Expiration Date: _____ 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:_____ or circle: NONE EXPECTED
Explain any allergies, reaction to/negative interaction with food or drugs: _____
Plan of Management for Side Effects: _____
Prescriber's Name/Title: _____ Phone # (____) ____-_____
Prescriber's Address: _____ Town: _____
Prescriber's Signature: _____ Date: ____/____/____

PARENT / GUARDIAN AUTHORIZATION:

I request that medication be administered to my child as described and directed above. I hereby request that the above ordered medication be administered by child care personnel and I give permission for the exchange of information between the prescriber and the child care nurse necessary to ensure the safe administration of this medication. I have administered at least one dose of the medication with the exception of emergency medications to my child without adverse effects.

Parent/Guardian Signature: _____ Relationship: _____ Date: ____/____/____

Parent /Guardian's Address: _____Town: _____State: _____

Home Phone # (____) ____-_____ Work Phone # (____) ____-_____ Cell Phone # (____) ____-_____

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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.)