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 <u>before</u> 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.

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 exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administ this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.) Lhave administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse efficient or inderstand that I must supply the school nurse, child care only) Parent/Guardian Signature Relationship Date / Parent/Guardian's Address	Address of Child/Student	g? 🗌	urse or F	Podiatrist):
Medication Name/Generic Name of Drug Controlled Drug? YES NO Condition for which drug is being administered:	Medication Name/Generic Name of Drug	g? 🗌	_//	
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: //	Condition for which drug is being administered:			
Specific Instructions for Medication Administration	Specific Instructions for Medication Administration		YES [] NO
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Explain any allergies, reaction to/negative interaction with food or drugs Plan of Management for Side Effects Prescriber's Name/Title Prescriber's Name/Title Prescriber's Signature Prescriber's Signature Date Prescriber's Signature Date Chool Nurse Signature (if applicable) Parent/Guardian Authorization: I request that the above ordered medication be administered to my child/student as described and directed above I I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for exchange of information between the prescriber and the school only. I I hereby request that the above ordered medication with the exception of emergency medications: to my child/student without adverse effection. Understand that I must supply the school with no more than a three (3) month supply of medication (school only.) Parent/Guardian Signature Relationship Date /_/_/ Parent/Guardian Signature Town 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 inhalers for asthma and carridge injectors for medical/aingence Self-administration of self-administration: YES Prescriber's suthorization for self-administration: YES No Signature Signature Date	Explain any allergies, reaction to/negative interaction with food or drugs			
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	Signature Signature			
	School nurse, if applicable, approval for self-administration: YES NO Signature		******	Date
	Today's DatePrinted Name of Individual Receiving Written Authorization and Medication	*****		
Fitle/Position	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.)