

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: _____

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 with the exception of emergency medications 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 or electronic) _____

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

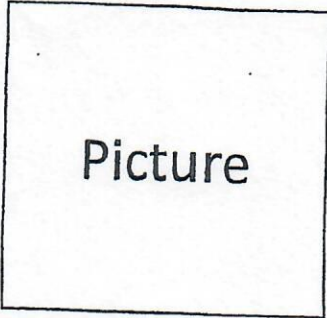
EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Child's Name: _____

DOB: _____ Child Care Provider: _____

History of Asthma: Yes (high risk for severe reaction) No



Signs of an allergic reaction include:

- Mouth: itching and swelling of lips, tongue, or mouth
- Throat: itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- Skin: hives, itchy rash, and/or swelling about the face or extremities
- Gut: nausea, abdominal cramps, vomiting, and/or diarrhea
- Lung: shortness of breath, repetitive coughing, and/or wheezing
- Heart: "thread" pulse, "passing out"

The severity of the symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!

If ingestion or insect sting is seen or suspected:
(Prescriber should number in order all appropriate actions)

- _____ Observe child for severe symptoms
- _____ Administer Epi Pen before symptoms occur
- _____ Administer Epi Pen if symptoms occur
- _____ Administer Benadryl (dose) _____
- _____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
- _____ Call 911 (and request a paramedic) and transport to ER if Epi Pen given

Preferred Hospital: _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED**

Parent Signature _____ Date _____ Prescriber Signature _____ Date _____

Emergency Contacts	Trained Staff Members
1. _____ Relation: _____ Phone: _____	1. _____ Room _____
2. _____ Relation: _____ Phone: _____	2. _____ Room _____
3. _____ Relation: _____ Phone: _____	3. _____ Room _____

For children with multiple allergies, use one form for each allergen