Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut, 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. **This form must be completed for each medication.**

Authorized Prescriber's Order (Physician, Dentist, Optometrist, PA, APRN, or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____ State_____

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 ____/____/____

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 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 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. Inhalers for asthma and cartridge injectors for medically-diagnosed allergies (epi pens) may be carried and self-administered with the written authorization of an authorized prescriber and written authorization. from a parent or guardian.

Prescriber's authorization for self-administration: ❑ YES ❑ NO

_____

Signature Date

Parent/Guardian authorization for self-administration: ❑ YES ❑ NO _____

Signature Date

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CAMP USE ONLY:

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.)