# 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 to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____
E-mail: _____ Cell Phone # (_____) _____-_____ Other Phone # (_____) _____-_____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication specified on this form: _____ YES _____NO
2. Student to possess medication specified on this form: _____ YES _____NO

Prescriber's Authorization and Signature: _____ Date:_____

Parent/Guardian Authorization and Signature: _____ Date: _____

School nurse (RN) Approval of self-administration (if applicable): _____ Date: _____

Printed Name of Individual Receiving Written Authorization and Medication _____
Title/Position/ _____ Date: _____ _

# Medication Administration Record (MAR)

**Name of Child/Student**_____ **Date of Birth** _____/_____/_____

**Pharmacy Name** _____ **Prescription Number** _____

**Medication Order**_____

| Date | Time | Dosage | Remarks | Was This Medication Self Administered? | Signature of Person Observing or Administering Medication |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |
| | | | | ☐ Yes ☐ No | |

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete** ☐ **Medication is appropriately labeled**

☐ **Medication is in original container** ☐ **Date on label is current**

**Person Accepting Medication (print name)** _____ **Date** ____/____/___