



Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? Yes No
 Relevant Side Effects of Medication _____ Plan of Management for Side Effects _____
 Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO
 If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____ Address _____

Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects.
 I request that medication be self-administered to my child as described and directed above.

Name of Parent/Guardian Authorizing Administration of Medication _____
 Relationship to Child: Mother Father Guardian/Other explain: _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Care Plan

Problem/Diagnosis	Symptoms/Observations	Plan

Name/Title/of Personnel Receiving Written Authorization and Medication _____ Signature _____

Name of Classroom Teacher _____ Signature _____

Health Consultant Name _____ Signature _____