

**MEDICATION ADMINISTRATION AUTHORIZATION FORM**  
**For 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 the following before any medications are administered.

- 1) Fill out one (1) Medication Administration Authorization form per medication
- 2) Submit all medication(s) prior to the start of Preschool/School, Summer Camp and/or other drop off program
- 3) **All medication(s) must be in original container/packaging and clearly labeled with:**
  - a) Child's name
  - b) Prescription (Rx) number
  - c) Date of prescription (Rx)
  - d) Name of medication
  - e) Directions for proper administration

All unused medication shall be destroyed if not picked up within one week after the child's last day of participation in programming, except for preschoolers staying on for summer camp or vice versa.

**Authorized Prescriber's Order (Physician, Physician's Assistant, Registered Nurse, Dentist)**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address of Child \_\_\_\_\_ Town \_\_\_\_\_

Medication Name \_\_\_\_\_ 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Stop Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_  None Expected

Explain any related allergies, reaction to/negative interaction with food or drugs \_\_\_\_\_

Prescriber's Name/Title \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date (MM/DD/YY):** \_\_\_\_\_

**Parent/Guardian Authorization**

I request that medication be administered to my child as described and directed above by the prescriber.

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/director of first aid necessary to ensure the safe administration of this medication. I understand that for school, I must supply the school with no more than a three (3) month supply of medication.

(For child care only) I have administered at least one dose of the medication, with the exception of emergency medications, to my child without adverse effects.

**Parent/Guardian Signature** \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 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 \_\_\_\_\_ (Sign & Date)

Parent/guardian authorization for self-administration:  YES  NO \_\_\_\_\_ (Sign & Date)

School nurse (if applicable) authorization for self-administration:  YES  NO \_\_\_\_\_ (Sign & Date)

**TURN OVER & COMPLETE TOP PORTION OF PAGE 2**



### Fill out this top portion as well prior to checking in any medications

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Pharmacy Name \_\_\_\_\_ Prescription Number \_\_\_\_\_  
Medication Order \_\_\_\_\_

### Medication Administration Record (MAR) –to be filled out by NCNC personnel only

Date	Time	Dosage	Remarks	Was this medication self-administered?		Signature of person observing or administering medication.
				Yes	No	

- Authorization form is complete
- Medication in original container
- Appropriately labeled with child's name & Rx info
- Date on label is current

Name of New Canaan Nature Center personnel receiving medication and written medication administration authorization \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_