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

New Canaan Nature Center

144 Oenoke Ridge
New Canaan, CT 06840-4198
Tel (203) 966-9577
Fax (203) 966-6536
www.NewCanaanNature.org

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	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

☐ **Authorization form is complete** ☐ **Appropriately labeled with child's name & Rx info**

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

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

Title/Position _____ **Signature** _____ **Date** _____