

## 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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 (\_\_\_\_) \_\_\_\_\_

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

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.**

Name of Day Care Program \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

**Name of Childcare Personnel Receiving Written Authorization and Medication** \_\_\_\_\_

**Title/Position** \_\_\_\_\_ **Signature (in ink)** \_\_\_\_\_

## Medication Administration Record (MAR)

Name of Child \_\_\_\_\_ 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

- |  |  |
|--|--|
| <input type="checkbox"/> Authorization form is complete      | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current            |

Person Accepting Medication (print name) \_\_\_\_\_ Date  
 \_\_\_\_/\_\_\_\_/\_\_\_\_