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 with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's 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 the 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 _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

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Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Please complete if your health care provider does not provide an Action Plan for Allergies.

Easton Community Center

Action Plan for Allergies if Anaphylactic

Child's Name_____ Grade_____
Allergic to _____
Symptoms of Anaphylaxis:

- **Mouth-itching, swelling of lips and/or tongue**
- **Throat-itching, tightness/closure, hoarseness***
- **Skin-itching, hives, redness, swelling**
- **Gut-vomiting, diarrhea, cramps**
- **Lung-shortness of breath, cough, wheeze***
- **Heart-weak pulse, dizziness, passing out***

ONLY A FEW SYMPTOMS MAY BE PRESENT. SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY.
*SOME SYMPTOMS MAY BE LIFE-THREATENING. ACT FAST!!!

If child ingests or thinks he/she ingested the above-named food but carries a disclaimer or stung by an insect (may contain, processed in, packaged in, etc) OBSERVE for onset of symptoms BEFORE initialing protocol sequence.

1-Administer Benadryl/Diphenhydramine
2-Observe child for symptoms of anaphylaxis
3-Administer epinephrine if symptoms occur
4-Call 911
5-Notify parent
**********If you notice symptoms of anaphylaxis first, skip step #1 and act on step #3.**

Date_____
Parent Signature_____
ECC Staff Member Signature Certified to Administer_____

Care Plan Form

Please complete if your health care provider did not provide an Action Plan for Asthma or mild allergies.

Date_____
Child's Name_____ Grade_____

Chronic Disease Assessment: Results taken from medical form submitted.
Circle One: Asthma: Mild Moderate Severe Exercise Induced Unclassified

Please explain reaction:
_____
_____

Diabetes: Type 1 Type 2
Anaphylactic Reaction: Insect Latex

Please list and explain reaction
_____
_____

Other_____
ECC Plan of Action
_____
_____

Parent Signature _____
ECC Representative Signature _____