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 (_____)_________________

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.**
- I request that medication be self-administered to my child as described and directed above.

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)** ____

FOOD ALLERGY TREATMENT

Patients Name: ______________________________ Date of Birth: ________________________

SPECIFIC FOOD ALLERGY(S): ____

Signs and Symptoms of an Allergic Reaction

Throat	itching of throat, sense of tightness in the throat, hoarseness, difficulty swallowing
Skin	hives, itch, rash, swelling of the face or extremities
Gut	nausea, abdominal cramps, vomiting, diarrhea
Lung	shortness of breath, repetitive coughing, wheezing, chest tightness
Cardiovascular	dizziness, faintness, loss of consciousness
Other	metallic taste, uterine contractions

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD, DO THE FOLLOWING: (check appropriate steps to follow)

☐ **Epinephrine**

1. Immediately administer epinephrine (adrenaline) by injection into the thigh, **without waiting** to see whether or not signs or symptoms of an allergic reaction occur
2. Call 911 for transport to the emergency room.

☐ **Benadryl First**

1. Administer Benadryl/diphenhyramine by mouth and observe for signs and symptoms of allergy for one hour.
2. If significant signs or symptoms of allergy occur (more than a few hives), **Immediately administer epinephrine** (adrenaline) by injection into the thigh.
3. Call 911 for transport to the emergency room.

☐ **Ephinephrine First**

1. Immediately administer epinephrine (adrenaline) by injection into the thigh, **without waiting** to see whether or not signs or symptoms of an allergic reaction occur
2. Call 911 for transport to the emergency room.
3. Administer Benadryl/diphenhydramine by mouth.

Father: ______________________ Home #______________ Work #_____________ Cell #_____________
Mother: ______________________ Home #______________ Work #_____________ Cell #_____________

Physician Signature: ____ Date __________________

I have received, reviewed and understand the above information.

Parent Signature: ____ Date___________________

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Medication Name ____ Controlled Drug? YES NO

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Is this medication to be self-administered by the child? Yes No

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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 ____

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- 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.

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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
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

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

☐ **Authorization form is complete** ☐ **Medication is appropriately labeled**

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

Person Accepting Medication (print name)_____________________________ **Date** _____/_____/_____