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)** _____**Date**_____

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

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)

☐ **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.

☐ **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.

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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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)** _____**Date**_____

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

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** _____/_____/_____