Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family 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: Please be sure to check all the necessary boxes!

☐ 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.)

Medication Administration Record (MAR)

Name of Child/Student____ **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**

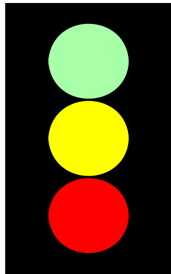
☐ **Date on label is current**

Person Accepting Medication (print name) __________________________________ **Date** _____/_____/____

Asthma Action Plan

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
www.ct.gov/dph/asthma

Name:		Birth Date:	Date:
Parent/Guardian Phone #'s:	Provider Phone #: Fax #: (or stamp)		
Important! Things that make your asthma worse (Triggers): ☐ smoke ☐ pets ☐ mold ☐ dust ☐ tree/grass/weed pollen ☐ colds/viruses ☐ exercise ☐ seasons: other:			



Severity Classification: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Intermittent

GO – You're Doing Well! USE THESE MEDICINES EVERY DAY TO PREVENT SYMPTOMS

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak Flow may be useful for some kids.

CONTROLLER MEDICINE **DIRECTIONS**

____

______________________________ ______________________________

☐ **If your child usually has symptoms with exercise then give:**

______________________________ ______________________________

☺ **Inhalers work better with spacers. Always use with a mask when prescribed.**

CAUTION – Slow Down! Continue with Green Zone Medicine and Add:

You have *any* of these:
- **First signs of a cold**
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

RESCUE MEDICINE **DIRECTIONS**

______________________________ ______________________________

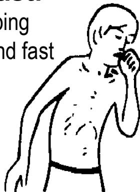
Then: Wait **20 minutes** and see if the treatment(s) helped
- ➢ If you are **GETTING WORSE** or **NOT IMPROVING** after the treatment(s) **GO TO RED ZONE**
- ➢ If you are **BETTER,** continue treatments every 4 to 6 hours as needed for 24 to 48 hours

Then: If you still have symptoms after 24 hours, CALL YOUR DOCTOR and if he/she agrees:
- ➢ Start: ______________________________

If rescue medication is needed more than 2 times a week, call your doctor at: ____________________

DANGER – Get Help! TAKE THESE MEDICINES AND SEEK MEDICAL HELP NOW!

Your asthma is <u>getting worse</u> fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous



RESCUE MEDICINE **DIRECTIONS**

______________________________ ______________________________

Then: Wait 15 minutes and see if treatment helped
- ➢ If **GETTING WORSE** or **NOT IMPROVING**, go to the hospital or **call 911**
- ➢ If you are getting **BETTER**, continue treatments every 4 to 6 hours and call your doctor – **say you are having an asthma attack and need to be seen TODAY!**

Then: **If your doctor agrees, start:** ______________________________

✓ Make an appointment with your primary care provider within **two days** of an **emergency visit, hospitalization**, or anytime for **ANY** problem or question with asthma

Nurse: Call provider for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

Parents: Call your doctor for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR ____________________ **as stated** *in accordance with CT State Law and Regulations 10-212a*

Self–Administration: ☐ This student **is** capable to safely and properly self-administer this medication **OR** ☐ This student **is not** approved to self-administer this medication

Signature:______________________**Provider Printed Name:**____________________**Date:**__________ **For use from** ______ **to** ______

Parent/Guardian Consent: REQUIRED
☐ I authorize this medication to be administered by camp personnel **OR** ☐ I authorize the student to self-administer medication.
I also authorize communication between the prescribing health care provider, the nurse, the medical advisor and camp-based clinic providers necessary for asthma management and administration of this medication.
Parent/Guardian Signature: ______________________________ **Date:** ____________