

**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

Day'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.)**



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## Individual Health Plan (IHP) - **ASTHMA**

Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Concern: **ASTHMA - Reactive Airway Disease (RAD)**

**Asthma symptoms may be:**

- Wheezing
- Coughing
- Shortness of Breath

**Action steps for when they have these symptoms:**

Have them sit down and rest. A drink of water may help.

Give \_\_\_ puffs of MDI (inhaler), \_\_\_\_\_.  
 (use spacer if needed; puffs one(1) minute apart)

Give Nebulizer treatment.

Notify Parent/Guardian.

Other: \_\_\_\_\_.

**\*\*Call 911 if symptoms get worse\*\***

Additional information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent Name (Print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent Signature: \_\_\_\_\_