Bolton Public Schools

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: _____

Dosage____ Method /Route____ Time of Administration____ Start Date___/___/___ End Date___/___/___

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 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

Today's Date_____ Printed Name of Individual Receiving Written Authorization and Medication_____

Title/Position_____ Signature (in ink)_____

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** _/_/____