AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY CHILD CARE PERSONNEL

If Town & Country Early Learning Centers chooses to administer medications, the Connecticut State Law and Regulations require a physician's, dentist's or advanced practice registered nurses' written order and parent or guardian's authorizations for a nurse, the director, assistant director, teacher, or child care provider to administer medications. Medications must be in the original pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, name of prescriber, and date of original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN, DENTIST, OR ADVANCED PRACTICE REGISTERED NURSE ORDER

Name of Child _____ Date _____

Address _____ DOB _____

Condition for which drug is being administered during child care hours _____

DRUG: Name, dose, and method of administration _____

_____

Time of administration _____

Medication shall be administered from _____ to _____
Date Date

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a control drug? _____ Allergies to food or drugs? If yes, list _____

Name of Prescriber _____ Prescriber signature _____
(Type or print)

Prescriber Address_____ Telephone _____

Authorization by Parent/Guardian for the administration of the above medication: Date _____

I hereby request that the above medication ordered by the physician/dentist/advanced practice registered nurse for my child _____ be administered by the nurse, director, assistant director, or teacher. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that I must supply Town & Country Early Learning Centers with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

I authorize Town & Country Early Learning Centers to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: ☐Yes ☐ No

Name _____ Signature _____

Address _____

Relationship to Child _____ Telephone _____