



WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER/PARENT'S PERMISSION

If a Child Day Care Center, A Group Day Care Home or Family Day Care Home 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, teacher or day 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 medications must be in the original container and labeled with the child's name.

PHYSICIAN, DENTIST, ADVANCED PRACTICE REGISTERED NURSE OR PHYSICIAN ASSISTANT

- 1. **Name of Child** _____ **Date of Birth** _____
Condition for which medication is being administered during day care hours: _____
 - 2. **Medication:** _____ **Date of Order:** _____
 - 3. **Dose** _____ 4. **Route:** _____ 5. **Time:** _____
- Medication shall be administered from _____ to _____
Date Date

Side effects to be observed, if any: _____ see package insert

Plan for management of side effects: call parent call health care provider other _____

Is this a controlled medication? _____ Allergies to food or medications? If yes, list _____

Interaction of medication with food: _____

Name of licensed Prescriber _____ Telephone _____
(Type or print)

Address _____ Licensed Prescriber signature _____

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, 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 the Child Day Care Center, Group Day Care Center or Family Day Care Home with the prescribed medication on the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication will be destroyed if it is not picked up within one week following termination of the order.

I authorized my child care provider/program to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: YES NO

Name Parent/Guardian _____ Signature _____
(Type or Print)

Address _____

Relationship to Child _____ Telephone _____

For Controlled substances, child care and parent must fill out the following:
 Amount/Quantity Received _____
 Child Care Provider signature/date: _____
 Parent/Guardian signature/date: _____

Signature of Certified Child Care Provider receiving and reviewing this form:
