

# WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER/PARENT'S PERMISSION

If a Child Day Care Center, A Group Day Care Home or a 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 medication 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 \_\_\_\_\_

Address \_\_\_\_\_

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 Home 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 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 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 following:

Amount/Quantity Received: \_\_\_\_\_

Child Care Provider signature/date: \_\_\_\_\_

Parent/Guardian signature/date: \_\_\_\_\_

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

