NEW CANAAN YMCA – CHILD DEVELOPMENT CENTER

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY DAY CARE PERSONNEL

If a Child Day Care Center or Group Day Care Home chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, the director, teacher or group day care home provider to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN OR DENTIST'S ORDER: Date _____ / _____/ _____

Name of Child: _____ Date of Birth _____/_____/_____
(First) (Last)

Street Address: _____ City/Town _____ State _____

Condition for which drug is being administered during day care hours: _____

_____

DRUG: Name of Drug, Dose and Method of Administration

Times of Administration:_____, _____, _____. Medication shall be administered from ___/___/___ – ___/___/___

Relevant side effects to be observed, if any _____

_____

If there are side effects, plan for management _____

_____

Is this a controlled drug? _____

Allergies to food or drug? If YES, list _____

Physician's / Dentist's Name _____ Phone ( ) _____
(Type or Print)

Street Address _____ City/Town_____ State _____

Physician's or Dentist's Signature _____

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

Date: _____/_____/_____

To day care nurse, director, teacher or group day care home provider:

I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by the Nurse, Director, or Teacher. I understand that I must supply the Child Day Care Center or Group Day Care Home 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 (1) week following termination of the order.

Name of Parent or Guardian _____ Relationship to child: _____
(Print Name)

Signature: _____

Street Address: _____ City/Town _____ State _____

Phone ( )_____

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MEDICATION ADMINSTRATION AUTHORIZATION / RECORD

Child's Name _____ **Prescriber's Name** _____

Medication _____ **Pharmacy** _____

Dosage _____ **Prescription #** _____

Method of Administration _____ **Medication Errors** _____

Date	Time	Dose	Signature of Person Giving Medicine	Comments

BEFORE ANY MEDICATION IS ADMINISTERED FOR THE FIRST TIME THE FOLLOWING ITEMS MUST E IN PLACE:

The authorization form is complete.	**( ) Yes**	**( ) No**
The medication is in a safety-cap container.	**( ) Yes**	**( ) No**
The original prescription label is on the medication container.	**( ) Yes**	**( ) No**
The name of the child is on the container.	**( ) Yes**	**( ) No**
The date on prescription is current? (Within the month for antibiotics and within the expiration date for medications which are so labeled).	**( ) Yes**	**( ) No**

_____ _____

(Staff Signature) **(Date)**

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