Bright Morning Star Daycare, llc

42 Jetland Street
Bridgeport, CT 06604
203-685-0181

Medical Care Plan

1. Please state the specific plan for administering meds.

2. How often should this med. Be administered?

3. Please give the period of time med should be given? For how long?

4. Should meds. be administered when there are certain symptoms?
(i.e.) when child is coughing, sneezing, wheezing, etc.

5. If this is a medication that the child may need to take for an extensive period of time, please put the dates (from and to).

**If necessary the stop date can be for one year if the child has to take daily.

Thank You

Bright Morning Star Daycare, LLc

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child ____________________________ Date of Birth ____/____/____ Today's Date ____/____/___

Medication Name ____ Controlled Drug? YES NO

Dosage _______________________ Method _____________________ Time of Administration_______________

Specific Instructions for Medication Administration ____

Medication Administration Start Date _____/_____/_____ Stop Date _____/_____/_____
Is this medication to be self-administered by the child? ______Yes _____No

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____ Known

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain ____

Prescriber's Name ____ Phone Number (_____)_________________

Prescriber's Address ____ Town _________________
Signature ____

Parent/Guardian Authorization:
_____ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

_____ **I request that medication be self-administered to my child as described and directed above.**

Name of Day Care Program ____ Today's Date _____/_____/_____
Child's Name __________________________________ Address ___________________________Town_________

Name of Parent/Guardian Authorizing Administration of Medication ____

Relationship to Child:___Mother ___Father ____ Guardian/Other explain: ______________________________

Address _____________________________________ Town ______________Phone Number (_____) ___________

Signature of Parent/Guardian Authorizing Administration of Medication _____________________________________

Name of Childcare Personnel Receiving Written Authorization and Medication ____________________________

Title/Position _______________________ **Signature (in ink)** ____

Medication Administration Record (MAR)

Name of Child ____ **Date of Birth** ______/______/______
Pharmacy Name ____ **Prescription Number** _______________
Medication Order____

Date	Time	Dosage	Remarks	Was This Medication Self Administered? (Circle)	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	
				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** _____/_____/_____