SAMPLE

Written Approval for Administration of Medication Training for Childcare

_____

Name of Student

_____ _____

Address of Student (Street Address, City/Town, State, Zip Code) Phone Number of Student

The student has successfully mastered and demonstrated the required training in the methods of medication administration that included the required curriculum areas specified in Section 19a-79-9a(b)(1)(B) and/or Section 19a 87b-17(b)(1)(B) of the Regulations of Connecticut State Agencies. In addition, the student has successfully completed training on the route(s) of administration noted below and therefore understands the indications, side effects, handling and methods of administration of such medication(s).

(Check all that apply)

☐	Oral, topical, and inhalant medication (valid for three years)	Expiration Date: _____
☐	Injectable medications by a premeasured commercially prepared auto-injector (valid for one year)	Expiration Date: _____
☐	Rectal medications (valid for three years)	Expiration Date: _____
☐	Injectable medications other than by a premeasured commercially prepared auto-injector (valid for three years)	Expiration Date: _____

Trainer Information:

_____

Full Name of Physician (MD/DO);
Pharmacist (R.Ph.), Physician Assistant (PA);
Advanced Practice Registered Nurse (APRN) or
Registered Nurse (RN)

License Number_____

_____

Signature / Title

_____ _____

Address Date of Training

_____ _____

Phone Location of Training

_____

Email