

## 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)

- |  |                        |
|--|------------------------|
| <input type="checkbox"/> Oral, topical, and inhalant medication (valid for three years)  | Expiration Date: _____ |
| <input type="checkbox"/> Injectable medications by a premeasured commercially prepared auto-injector (valid for one year)  | Expiration Date: _____ |
| <input type="checkbox"/> Rectal medications (valid for three years)-Family Child Care Providers Only   | Expiration Date: _____ |
| <input type="checkbox"/> Injectable medications other than by a premeasured commercially prepared auto-injector (valid for three years)-Family Child Care Providers Only | 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