STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES
OFFICE OF LEGAL AND GOVERNMENTAL AFFAIRS

Use of this authorization form shall be limited to persons residing in DDS funded residences who are diagnosed as COVID-19 positive or as presumptive positive by a physician/healthcare provider, and who are prescribed off-label use of medications for the treatment of COVID-19.

This authorization acknowledges that medications prescribed for treatment of COVID-19 shall be administered by licensed nurses and/or medication administration certified employees. The requirement for a review by the DDS Institutional Review Board (IRB), specific to the treatment of COVID-19 is hereby waived.

GUARDIAN'S AUTHORIZATION

I, _____, am the Plenary Guardian or Limited Medical
Guardian's name

Guardian, for _____, an individual who is in the care of
Individual's name

the Department of Developmental Services. _____ has been prescribed
Individual's name

one or more medications by his/her physician, which are being used for the purpose of treating the Coronavirus, also known as COVID-19, or the symptoms of this illness. As the guardian, I understand that currently, there are no standard medications for the treatment of this virus and the prescribed medications are being used for a non-standard, off-label, purpose.

During this Health Emergency, I hereby authorize the Department of Developmental Services to administer these medications as prescribed by _____
prescribing physician or nurse practitioner

to _____ for the course of the treatment.
Individual's name

The Guardian confirms that prior to authorization, the prescriber has discussed with Guardian all components of informed consent, including but not limited to any and all possible side effects of off label use of the prescribed medication.

_____ _____
Date Guardian or Limited Guardian, Medical