

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. The first dose of any medication must be given at home. Medications must be brought to school by a parent/adult, in the original properly labeled container, dispensed by a physician/pharmacist. No more than a 45-day supply is to be stored in school.

Prescriber's Authorization

Name of Student _____ Date of Birth _____ Grade _____

Address _____ Telephone _____

Condition for which drug is being administered _____

Drug Name _____ Dose _____ Route _____

Time of Administration _____ If PRN, frequency _____

Relevant side effects _____ None expected _____ (Specify): _____

ALLERGIES _____ **NO** _____ **YES (specify)** _____

Medication shall be administered from _____ to _____

Month / Day / Year

Month / Day / Year

Prescriber's Name/Title: *(Type or print)* _____

Use for Prescriber's Stamp

Telephone _____ Fax _____

Address _____

Prescriber's Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. The first dose of any new medication must be given at home. The school nurse has my permission to discuss this medication, and the reason it is being ordered, with the authorizing practitioner.

Administer on field trips: _____ **yes** _____ **no** **Administer on early-dismissal days:** _____ **yes** _____ **no**

Parent/Guardian Signature _____ Date _____

Parent's Home Phone # _____ Work # _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Prescriber's authorization for self-administration _____ **yes** _____ **no** _____

Signature

Date

Parent/Guardian authorization for self-administration _____ **yes** _____ **no** _____

Signature

Date

School Nurse approval for self-administration _____ **yes** _____ **no** _____

Signature

Date