New Milford Public Schools **School:** _____ **Grade:** _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION 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. Medications must be in the original properly labeled container and dispensed by a physician or pharmacist.

PRESCRIBER'S AUTHORIZATION

Name of Student: _____ Date of Birth: _____

Address: _____ City/Town: _____

Condition for which drug is being administered: _____

Drug Name : _____Generic 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 _____
(up to 12 months) Month/Day/Year Month/Day/Year

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

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

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 three month 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.
I grant permission for the school nurse to exchange information with this prescriber regarding the administration of this medication.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work # _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

*Self-administration of a medication **may** be authorized by the prescriber and parent/guardian for **certain** medications and **must** be approved by the school nurse in accordance with Board policy and district nursing protocols.*

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 _____
Received by:_____ Date Med Authorization received_____Date Medication received_____