

**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): \_\_\_\_\_

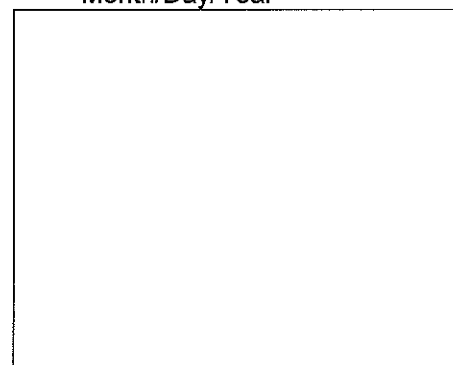
Medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_  
( up to 12 months) Month/Day/Year Month/Day/Year

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 \_\_\_\_\_