Newington 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 (including Generic) : _____ Dose: _____ Route: _____

Time of Administration: _____ Frequency, if PRN _____

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)

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 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.
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 _____
(Signature) (Date)

SCHOOL MEDICATION POLICY

For the protection of your child as well as the other children in school, we would like to review the policy for the administration of medication during school hours.

No medication will be administered to a student during school hours unless a written request from both parent and prescriber accompanies the medication. The medication, in its original container, should be brought to the school by a parent or responsible adult and not sent with the student. The label on the medication and the prescriber's written order must include the name of the medication, the dosage, the time to be given, the length of time to be given, and the diagnosis.

This policy will be in effect for any medication to be given in school whether the length of time is to be one day or for the school year.

Please call the school nurse for any questions regarding medication, and to obtain the proper forms.