# North Haven Public Schools

## 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, optometrist, advanced practice registered nurse or physician's assistant and for interscholastic and intramural athletic events only, a podiatrist) and a parent/guardian's written authorization for the nurse, or in the absence of the nurse, qualified school personnel to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.*

### Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is to be administered: _____

Drug Name: _____ Dose: _____ Route:_____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ Not 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**

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### PARENT/GUARDIAN AUTHORIZATION TO ADMINISTER MEDICATION AND FOR THE EXCHANGE OF INFORMATION

*Connecticut State Law and Regulations 10-212a-2 require the written permission of the parent/guardian for the exchange of information between the prescriber and the school nurse. I hereby request that the above ordered medication be administered by the school nurse, or qualified school personnel. I understand that I must supply the school with no more than a 3 month supply of medication, and 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 also give my consent for the exchange of information between my child's prescriber and the school nurse, if needed, to ensure the safe administration of medication.*

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Work #: _____ Cell #: _____

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### SELF ADMINISTRATION OF MEDICATION AUTHORIZATION /APPROVAL

*Self Administration may be approved by the prescriber, school nurse, and parent/guardian in accordance with Board policy.*

Prescriber's Authorization of self administration: ☐ Yes ☐ No _____
Signature Date

Parent/Guardian authorization for self Administration: ☐ Yes ☐ No _____
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No _____
(not required for inhalers or cartridge injectors) Signature Date