

# 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

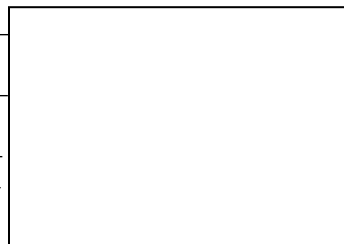
Prescriber's Name/Title: \_\_\_\_\_

(Type or Print)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Use for Prescriber's Stamp

### 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 #: \_\_\_\_\_

### 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