School District: _____ School: _____ Grade: _____

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 parent/ guardian written authorization, for the nurse, or in the absence of the nurse, designated qualified personnel to administer medication. Medications must be brought in the original properly labeled container and dispensed by a physician/pharmacist.

PRESCRIBER'S AUTHORIZATION/MEDICATION PLAN

Name of Student: _____ Date of Birth: ___/___/__ _

ALLERGIES: ☐ NO ☐ YES (specify) _____

Condition(s) for which drug(s) is being administered: _____

Drug and Generic Name (Both required by State of CT): _____

Dose: _____ Route: _____

Time of administration: _____ If PRN, Frequency_____

Relevant side effect: ☐ None expected ☐ Specify: _____

*If permitted to self administer medication, please note below.

Medication(s) shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

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

Telephone: _____ Fax: _____

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 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of order or end of school. I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of such medication. I understand how each of the above medication is to be administered including the condition, dosage, time frequency, route and relevant side effects.

Please check appropriate box and sign:

Please administer the above medication on days with: Early Dismissal: ☐ YES ☐ NO Late Arrival: ☐ YES ☐ NO
Field Trips: ☐ YES ☐ NO Overnight Trips: ☐ YES ☐ NO

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____Work #: _____ __Cell Phone #: _____

Student Signature: _____ Date: _____

*SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

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

10/11 prepared by RHPS