New Milford Public Schools School: Fax:

Authorization for the Administration of Medication by School

In Connecticut, administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication **before** any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for the medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Nurse or Podiatrist):

Name of Student _____ Date of Birth ___/___/_____ Today's Date: ___/___/____
Address of Student _____ Town _____

Medication Name/Generic Name of drug _____Controlled Drug? ❑YES ❑ NO
Condition for which drug is being administered: _____
Specific Instructions for Medication Administration _____
Dosage _____ Method/Route _____
Time of Administration _____ If PRN, frequency _____
Medication shall be administered: Start Date: ___/___/_____ End Date: ___/___/_____
Relevant Side Effects of Medication _____ ❑ None Expected
Explain any allergies, reaction to/negative interaction with food or drugs _____
Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number _____-_____-_____
Prescriber's Address _____ Town _____
Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

❑ I request that the medication be administered to my child as described and directed above

❑ I hereby request that the above ordered medication be administered by the school and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a 3 month supply of medication.

Parent/Guardian Signature _____ Relationship _____ Date ___/____/___
Parent/Guardian's Address _____ Town _____ State _____
E-mail _____ Cell _____ Other phone _____

SELF ADMINSTRATION AND/OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized parent/guardian in accordance with board policy. In a school: 1. Inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. Students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. Students who are 6 years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication: ____ YES ____ NO
2. Student to possess medication: ____ YES ____ NO

Prescriber's Authorization/Signature _____ Date ____/_____/_____
Parent/Guardian Authorization/Signature _____ Date ____/_____/_____
School nurse (RN) Approval of self-administration (if applicable) _____ Date ____/____/_____
Printed name of individual Receiving Written Authorization and Medication _____
Title/Position _____ Date _____/_____/_____

REV 11/26/2019