West Hartford Public Schools

50 South Main Street, West Hartford, Connecticut 06107 Phone: 860-561-6600

Authorization for Self Administration of Inhaled Asthma Medication, Auto-injector Allergy Medication and Insulin

To the Parent/Guardian: Students receiving or taking **any** medication at school must have a written order from a Doctor, Dentist, APRN or PA licensed to practice in Connecticut or any other state, as well as parental permission on file in the office of the School Nurse. If the Nurse does not know what medications a student may be taking, she/he cannot function effectively in the event of an emergency situation. The prescriber and parent/guardian may authorize self-administration of asthma, allergy and insulin medication. Medication must remain in the container in which it was purchased.

I have read and understand the above statement and assume responsibility for granting permission for my child to self-administer medication as approved and instructed below.
I understand it would benefit my child for the School Nurse to be supplied with back-up medication in the event the medication is lost or misplaced.

Parent/Guardian Signature_____ Date_____

Address_____ Phone #_____

To the Physician: Please fill out the following section.

Student name_____ Date of Birth_____

Condition for Prescribing_____

Medication name_____ Dose_____ Route_____

Time of Administration/Frequency_____

Medication administrated from Start Date_____ Finish Date_____

Relevant side effects_____

Allergies_____ Special instructions_____

1. I have conferred with this child's parents and feel that this medication may be self - administered.
2. This student has been appropriately instructed regarding self -administration.

Prescriber's Name/Title_____ Phone #_____

Address_____

Prescriber's Signature_____ Date_____