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HAMDEN PUBLIC SCHOOLS MEDICATION AUTHORIZATION FORM **2018 - 2019**

Connecticut Law requires a written medication order from an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and written authorization from the parent or guardian, for the school nurse or qualified school personnel to administer medications. Over-the-counter medications must be in their original unopened containers. Prescription medications must be in the original container dispensed and labeled by the pharmacist. All medications must be delivered to school by a responsible adult.

Self-administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and parent/guardian. All other medications considered for self-administration must be approved by the school nurse in accordance with Board policy to confirm student safety and competency with medication procedure.

PRESCRIBER'S AUTHORIZATION

(Only one child per form)

Name of Student: _____ Date of Birth: ____/____/_____

Condition for which medication is indicated: _____

Allergies: _____ ☐ NKDA

Drug Name: _____ Generic Name: _____

Dose: _____ ☐ mg ☐puffs ☐amp ☐other Route: ☐ inhaled ☐ spacer ☐ PO ☐IM ☐ SC ☐Other

Relevant Side Effects: _____ ☐ **none expected**

Time of Administration _____☐AM ☐PM **PRN**☐ **Frequency:** Q _____ Hours

Medication shall be administered from ____/____/_____ to ____/____/_____ (up to 12 months)

Prescriber's Authorization for Self-Administration ☐Yes ☐ No

By checking Yes to self-administer, I confirm that the student is competent to safely administer this medication for the management of the condition for which it is prescribed.

Prescriber Signature _____ Date: ____/____/_____

(Printed or stamped) **Name:**

Phone Number:

Fax Number:

Parent/Guardian Authorization

I have read and understand the Procedures for Requesting Medication Administration located on the second page of this form. I hereby consent to communications between the school nurse and the prescriber that are necessary to insure the safe administration of this medication.

I request that the medication ordered above be administered by school personnel. ☐Yes ☐ No

I authorize this student to self-administer this medication. ☐Yes ☐ No

Parent/Guardian Signature: _____ Date: ____/____/_____

Phone Numbers: Home_____ Work_____ Cell_____.

School Nurse Approval for Self-Administration ☐Yes ☐ No ☐Not required for inhalers or cartridge injectors.

Signature: _____ Date: ____/____/_____

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PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

Any child requiring a **prescription or over-the-counter medication** during the school day or during intramural or interscholastic athletic events must have a completed medication authorization on file with the nurse.

The medication must be delivered to the school nurse by a responsible adult. Parents/Guardians will be required to come to school and pick up/review any medication a student carries to school that is not authorized for self-carry

These procedures promote safe practices for students and staff. **Please read them carefully.**

1. **For each medication** that must be administered at school daily or as-needed, the parent must obtain the written order of an authorized prescriber (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) using *Hamden Public Schools Medication Authorization Form* (see Page 1).

A new order is required each year and, if so prescribed**, may be effective from July 1st through June 30th** of the given year. A medication order dated July 1 of a year will cover summer programs and the upcoming school year.

2. **The authorized prescriber must fill in the following information requested on the form**:

    a. Name of medication, the generic name of the medication (NEW), and strength of the medication;
    b. Indications for the administration of this medication in school (condition, diagnosis);
    c. Amount (dosage) of the medication to be administered and route of administration.
    d. Potential side effects of the medication.
    e. Time of day that the medication is to be administered. For PRN (as-needed) medications the frequency must be included.
    f. Duration of the order for administration of the medication (up to 12 months from July 1 through June 30th of **the same school year**.
    g. If applicable, authorization for self-administration in school.

3. A **parent or guardian must sign** the "Parent/Guardian Authorization" portion of the form and, if applicable, provide authorization for self-administration in school.

4. Prescription medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with student's name, the authorized prescriber's name, and the medication instructions

5. **Over-the-counter medications** must be in their original **unopened** containers.

6. Once the nurse has reviewed the medication order and developed a plan for self-administration, the student may carry the medication to/from school each day and maintain its safe control at all times.

7. Self-administration plans approved for the school day also **extend to extra curricular** activities and athletics.

8. No more than a **three (3) month supply** may be stored at a school. Except for students attending an Extended School Year program, **unused medication must be destroyed** if not picked up by a responsible adult by the end of the last day of school.

Thank you for your cooperation. Please contact the school nurse or Hamden School Health Services, 203 407-2084, if you have any questions.