MADISON SCHOOL HEALTH SERVICES

Authorization for the Administration of Medication 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 sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, other qualified school personnel to administer medication.

LICENSED PRESCRIBING PROVIDER'S ORDER:

Name of Student_____D.O.B._____ Grade_____

Condition for which drug is indicated_____

Name of medication (including generic) & dosage_____

Time & mode of administration_____ Duration of order_____to_____

Is this a controlled drug? _____ DEA number_____

Side effects_____

SELF ADMINISTRATION 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 authorizes self – administration and confirms that the student has been instructed to safely and properly administer this medication. Yes ◯ No ◯

_____

Prescribing provider's signature

Per ST of CT only hand signature of prescriber or electronic
No stamped or co-signed signatures permitted

Date: _____ Phone: _____ **Provider stamp**_____

Printed name, address & phone

SCHOOL AUTHORIZATION for the student to self-administer above prescribed medication.

School RN_____ Yes ◯ No ◯ NR* ◯ *not required for inhalers or cartridge injectors

AUTHORIZATION OF PARENT/ GUARDIAN: I request that my child, _____, be assisted/ supervised (to include self-administration medications as needed) in taking the above medication at school. I understand that I must supply the school with no more than a 3 month supply of prescriptive medication. All medications, prescription and non prescription, shall be delivered and stored in their original containers/box. I will comply with the policies and procedures determined by the school district. I consent to communication between school nurse and prescriber regarding any issues with this medication.

Parent/Guardian Authorization to Self-Administer Yes ◯ No ◯ Administer on ½ days Yes ◯ No ◯

Student attends: Before-School ☐ After-School ☐ Administer on Field Trips Yes ◯ No ◯

Cell Phone_____ _____

Home Phone_____ **Signature of parent/guardian** **Date** **rev 2/19**