

# TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant, Optometrist, or Podiatrist (for interscholastic and intramural events only), licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

### MEDICATION ORDER

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which Drug is being Administered \_\_\_\_\_

**BRAND Name AND GENERIC Name of Drug (PER STATE REGULATION)**

\_\_\_\_\_

Dosage \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time to be given in school: \_\_\_\_\_

Administer Drug: from \_\_\_\_\_ to \_\_\_\_\_  
Date Date

Side Effects/Plan for Management: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Self-administration of medication means** that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

\_\_\_\_\_ M.D./D.O./D.D.S./A.P.R.N./P.A./O.D./D.P.M.  
Date Signature of Prescriber

\_\_\_\_\_  
Print Name of Prescriber

\_\_\_\_\_  
Address and Telephone

# TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

## AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant, Optometrist or Podiatrist (for interscholastic and intramural events only), licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Medication \_\_\_\_\_

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

**Self-administration of medication means** that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one):    Yes    No

For daily medication – Plan for early dismissal days (check one):

\_\_\_ Give medication in school as usual

\_\_\_ Do not give medication in school

-    **Plan for delayed opening:**

**On days that opening of school is delayed, the parent or guardian must notify the school nurse if any change in the student's medication schedule is needed.**

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of that medication order in school.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Print Name of Parent or Guardian