School District: _Suffield_____
School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE 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 assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____
Address: _____
Condition for which drug is being administered: _____
Name and Generic name of Drug: _____
Dose: _____ Route: _____
Time of Administration: _____ If PRN, frequency: _____
Relevant side effects: _____None expected Specify: _____
ALLERGIES: NO YES (specify): _____
Medication shall be administered from: _____ to _____
(Month / Day / Year) (Month / Day / Year)

****

Prescriber's Name/Title: _____
Telephone: _____ FAX: _____
Address: _____
Prescriber's Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

****

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel 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 three (3) month supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____
Parent's Home Phone #:_____ Cell #_____ Work #_____

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SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL (Grades 6 -12)

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board Policy. In the case of inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self administration:	Yes	No	
_____			_____
Signature			Date

Parent/Guardian authorization for self administration:	Yes	No	
_____			_____
Signature			Date

School nurse approval for self administration:	Yes	No	
_____			_____
Signature			Date

kmm
NURSE/authoradminofmed 7-2012