STUDENT HEALTH FORMS

Suffield Academy Health Center 185 North Main Street Suffield, Connecticut 06078
Phone: 860-386-4503 | Fax: 860-386-4544 | healthcenter@suffieldacademy.org

STUDENT INFORMATION

FIRST NAME _____ LAST NAME _____ DOB _____

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Suffield Academy's preferred pharmacy: Partners Pharmacy, 61 Thompson Road, East Windsor, Connecticut 06088
Phone: 860-623-3000 Fax: 855-547-5702 NPI # 1336170349 Escribe capable.

We request that controlled substances be blister packed. Partners Pharmacy automatically blister packs and they deliver to the school. They accept most insurances.

Any medication prescribed for a student must be reported to the Health Center. This form must be completed for all controlled substances, mood altering medications, and any other medication to be dispensed by school personnel. Connecticut State statute requires a physician's or dentist's written order and the parent's/guardian's authorization for a nurse to administer prescription medicine.

Medications must be in pharmacy-prepared blister-pack containers and labeled with the student's name, name of the drug, strength, dose, frequency, physician's or dentist's name, and date of the original prescription. The physician's name and order must be the same on the authorization form and prescription bottle. All prescriptions may be included on this form. Photocopies of this form are acceptable.

PHYSICIAN'S ORDER

Diagnosis _____

I have evaluated/examined the student on _____ (DATE) and plan to reassess the medication treatment plan on _____ (DATE)

Drug: [name, dose, frequency and method of administration]_____

Medication shall be administered from _____ (DATE) to _____ (DATE)

Relevant side effects to be observed, if any _____

If there are side effects, give plan for management:_____

_____

Is this a controlled drug? ❑ Yes ❑ No If yes, DEA #_____

PRINT OR TYPE NAME AND ADDRESS OF EXAMINING PHYSICIAN

_____

_____

Physician's Signature [required]

_____ _____ (DATE)