DARIEN PUBLIC SCHOOLS

School: _____ **Grade:** _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a9 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician's assistant or optometrist, and, for interscholastic athletic events only, a podiatrist) and parent/guardian written authorization, for school nurses, or in the absence of a nurse, other designated personnel to administer medication, including over-the-counter drugs. Medications must be in the original, properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container. ALL medications must be delivered to school by a parent, guardian or other responsible adult.

Prescriber's Authorization

Name of Student: _____ **Date of Birth:** _____

Address: _____

Indication(s) for medication _____

Drug Name: _____ **Generic Name:** _____ **Dose:** _____

Route: _____ **Frequency:** _____ **Time of Administration:** _____

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: _____
(***type or print***)

Telephone: _____ **Fax:** _____

Address: _____

_____

Prescriber's Signature: _____ **Date:** _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 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 #: _____ **Work #:** _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a chronic medical condition, self-administration of emergency and some other non-controlled medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-4, and Board policy.

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: ☐ **NR*** ☐ **Yes** ☐ **No** _____
Signature **Date**

*NR means *not required*

Received by _____ **Date of Receipt** _____

DARIEN PUBLIC SCHOOLS

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a prescription or over-the-counter medication during the school day or during interscholastic athletic events, you must follow the procedures required by Darien Public Schools, Connecticut General Statutes, Sec. 10-212a, and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-9. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, physician assistant or optometrist, and, for interscholastic athletic events only, a podiatrist) using Darien Public Schools' form, *Authorization for the Administration of Medicine by School Personnel* (see over). 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 medical order dated July 1 of a year will cover summer programs *and* the upcoming school year.
2. The authorized prescriber must fill in the information requested on the form:
   a. Name of Student.
   b. Name of medication and the generic name of the medication to be administered.
   c. Dosage of the medication to be administered.
   d. Route of administration of the medication to be administered.
   e. Time of day that the medication is to be administered.
   f. Frequency of Administration of the medication to be administered
   g. Indications for the administration of this medication in school (condition, diagnosis);
   h. Any potential side effects of the medication including overdose or missed dose of the medication.
   i. Duration of the order for administration of the medication (up to 12 months from July 1 through June 30th of the same school year).
   j. If applicable, authorization for self-administration in school.
   k. Written signature of the prescriber.
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. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student's name, the authorized prescriber's name, and the prescription.
5. The medication and completed authorization form **must be delivered to the school nurse by a parent, guardian or other responsible adult**, except that, once the nurse has reviewed the medical order and developed a plan for self-administration, the student is responsible to carry the medication to/from school each day and maintain its safe control at all times.
6. Self administration plans approved for the school day also extend to interscholastic athletic events.
7. Self administration of controlled medication is not permitted.
8. No more than a three (3) month supply may be stored at school. **Unused medication must be destroyed** if not picked up by a parent or guardian by the end of the last day of school.

It may be helpful to take this authorization form (side one) with you to your healthcare provider in case medication is prescribed for your child.

Thank you for your cooperation. Please contact the school nurse if you have any questions.

Record of Medication Received

Student Name:_____ Medication Name/Strength: _____

DATE	COUNT	PARENT/ADULT SIGNATURE	SCHOOL NURSE SIGNATURE