Authorization for the Administration of Medication by School Personnel

In Connecticut schools, administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student ______________________________ Date of Birth____/____/____ Today's Date____/____/____

Medication Name/Generic Name of Drug_______________________________________Controlled Drug ☐ YES ☐ NO

Condition for which drug is being administered: ____

Specific Instructions for Medication Administration ____

Dosage______________________________Method/Route____

Time of Administration__________________________If PRN, frequency______________________________

Medication shall be administered: Start Date:_____/_____/_____End Date:______/_____/______

Relevant Side Effects of Medication____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs____

Plan of Management for Side Effects ____

Prescriber's Name/Title____Phone Number (_____) ______________

Prescriber's Address____Town ___________________

Prescriber's Signature____Date______/_____/_____

Prescriber's authorization for self-administration: YES ☐ NO ☐

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered at school, I and I give permission for the exchange of information between the prescriber and the school nurse that is 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 (school only.)

____

Parent/Guardian Signature___________________________________Relationship______________Date____/____/_____

Parent /Guardian's Address____Town__________________State______

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and must be authorized by a parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and a parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-supply an over-the-counter sunscreen product with only the parent/guardian written authorization.

Student to self-administer medication specified on this form: YES ☐ NO ☐

Parent/Guardian authorization and signature: ____
Signature Date

School nurse, if applicable, approval for self-administration: ____
Signature Date

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

12/2019