

Coventry Public Schools
Authorization for the Administration of Medication by School Personnel

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and written authorization of a parent/guardian for a school nurse or in the absence of the nurse, a designated principal or teacher to administer medication.

NOTE: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and the date of the prescription.

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

Child/Student Name _____ Date of Birth ___/___/___ Today's Date ___/___/___

Address of Child/Student _____ Town _____

Medication Name/Generic Drug Name _____ 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 ___/___/___

School Nurse Signature _____

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 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

Parent/Guardian Signature _____ Relationship _____ Date ___/___/___

Parent /Guardian's Address _____ Town _____ State _____

E-mail: _____ Cell Phone _____ - _____ - _____ Other Phone _____ - _____ - _____

SELF ADMINISTRATION AND/OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by 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 parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

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

2. Student to possess medication specified on this form: YES NO

Prescribers Authorization and Signature: _____ Date ___/___/___

Parent/Guardian Authorization and Signature: _____ Date ___/___/___

School nurse (RN) Approval of self-administration : _____ Date ___/___/___