COVENTRY PUBLIC SCHOOLS

FORM B: Authorization for the Administration Of Medicine by School Personnel

**ONLY ONE MEDICATION PER FORM ** Must be signed by DOCTOR & PARENT/GUARDIAN

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 brought to and from the school by a parent/guardian or other responsible adult. All medications must be in the original pharmacy or commercially labeled container.

Student's Name: _____ Date of Birth: _____

Address: _____ Town: _____

Condition for which Medication is being administered: _____

Medication Brand Name: _____ Generic Name: _____

Dose: _____ Route: _____ Time of administration: _____

Is this a controlled drug? ☐ No ☐ Yes

Relevant side effects: ☐ none expected ☐ yes (specify): _____

ALLERGIES: ☐ NO ☐ YES (specify): _____

Medication shall be administered from: _____ to _____
(month/day/year) (month/day/year)

Prescriber Signature: _____

Date: _____

Prescriber Stamp

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION

Note: self administration of medication may be authorized by the prescriber & parent/guardian and must be approved by the school nurse. These include emergency medications only: Asthma Inhalers, Epinephrine & Benadryl for anaphylaxis, Insulin & glucose tabs/gel.

Other medications will be considered on an individual basis in consultation with the school nurse supervisor and medical advisor.

Prescriber 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)

PARENT/GUARDIAN AUTHORIZATION

I here by request that the above ordered medication be administered by school personnel. I understand that I must supply 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.

I authorize and consent for the school nurse to contact the above health care provider to discuss and obtain information for the safe administration of this medication.

Parent/Guardian Signature: _____ Date: _____

Home phone#: _____ Work phone #: _____ Cell phone#: _____

**This medication will be sent on fieldtrips and given on early dismissal days unless otherwise specified.*

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