AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmicist. Over -the-counter medications must be delivered in an unopened, properly labeled container.

PRESCRIBER'S AUTHORIZATION

Name of Student _____ Grade _____ Date of Birth _____

Address _____

Condition for which drug is being administered _____

Drug Name/ Strength _____ Dose _____ Route _____

Time of administration _____ If PRN, frequency _____

Relevant side effects ☐ None expected ☐ Specify _____

ALLERGIES ☐ NO ☐ YES (specify) _____

Medication shall be administered from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Prescriber's Name/Title _____ (Type or Print)

Telephone _____ Fax _____

Address _____

_____

Prescriber's Signature _____ Date _____

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 45 day 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, which ever comes first.

Parent/Guardian Signature _____ Date _____

Parent's Home Phone # _____ Work # _____

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips. _____

I DO / DO NOT wish medication ADMINISTERED on shortened days. Signature Date

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication (inhalers and EpiPens) may be authorized for middle school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT 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 ☐ Yes ☒ No _____ Signature Date

Received by _____ Date of Receipt/Form _____ Date of Receipt/Medication _____