Darien Public Schools

School:______________________ Grade:__________

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 program 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

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

Address of Child/Student ______________________ Town ______________

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 ____/____/________

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 ______________________ 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; and 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

Prescriber's Authorization and Signature: ______________________ Date: ______________

Parent/Guardian Authorization and Signature: ______________________ Date: ______________

School nurse (RN) Approval of self-administration (if applicable): ______________________ Date: ______________

Printed Name of Individual Receiving Written Authorization and Medication ______________________

Title/Position/ ______________________ Date: ____________

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-possession and self - administration plans approved for the school day also extend to interscholastic athletic events.
7. Self-possession and 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