



Student Health Forms

Suffield Academy Health Center 185 North Main Street Suffield, Connecticut 06078
Phone: 860-386-4503 | Fax: 860-386-4544 | healthcenter@suffieldacademy.org

Student Information

FIRST NAME

LAST NAME

DOB

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Suffield Academy's pharmacy: Partners Pharmacy, 61 Thompson Road, East Windsor, Connecticut 06088
Phone: 860-623-3000 Fax: 855-547-5702 NPI # 1336170349 eScribe capable.

All medications must be packaged in individual dosing packs. Pharmerica automatically packages medications in individual dosing packs and they deliver them to the school. They are a nationwide company and accept most insurances.

Any medication prescribed for a student must be reported to the Health Center. This form must be completed for all controlled substances, mood-altering medications, and any other medication to be dispensed by school personnel. Connecticut State statute requires a physician's or dentist's written order and the parent's/guardian's authorization for a nurse to administer prescription medicine.

Medications must be in pharmacy-prepared blister-pack containers and labeled with the student's name, name of the drug, strength, dose, frequency, physician's or dentist's name, and date of the original prescription. The physician's name and order must be the same on the authorization form and prescription bottle. All prescriptions may be included on this form. Photocopies of this form are acceptable.

PHYSICIAN'S ORDER

Diagnosis \_\_\_\_\_

I have evaluated/examined the student on \_\_\_\_\_ and plan to reassess the medication treatment plan on \_\_\_\_\_
DATE DATE

Drug: [name, dose, frequency and method of administration] \_\_\_\_\_

Medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_
DATE DATE

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, give plan for management \_\_\_\_\_

Is this a controlled drug? Yes No If yes, DEA # \_\_\_\_\_

PRINT OR TYPE NAME AND ADDRESS OF EXAMINING PHYSICIAN

Physician's Signature [required]

DATE