

**GRISWOLD ELEMENTARY SCHOOL**

303 Slater Ave., Griswold, CT 06351

Ph: (860) 376-7615

Fax: (860) 376-7612

GRISWOLD MIDDLE SCHOOL

211 Slater Ave., Griswold CT 06351

Ph: (860) 376-7624

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GRISWOLD HIGH SCHOOL

267 Slater Ave., Griswold CT 06351

Ph: (860) 376-7640

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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 (Sec. 10-212a-4) and Board Policy. Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.

Student Name: _____ Date of Birth (M/D/Y): ____/____/____ Today's Date: ____/____/____

Address of Student: _____

Medication Name/Generic Name of Drug: _____ Controlled Drug: ☐ Y ☐ N

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration: _____

Dosage: _____ Method/Route: _____

Time(s) 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: _____

Prescriber's Authorization and Signature: _____ Date: ____/____/____**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 (RN) 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 to Student: _____ Date: ____/____/____

Email: _____ 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 (6) 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: ☐ Y ☐ N2. Student to possess medication: ☐ Y ☐ N**Prescriber's Authorization and Signature:** _____ Date: ____/____/____**Parent/Guardian Signature:** _____ Date: ____/____/____

School Nurse (RN) Approval of self-administration (if applicable): _____ Date: ____/____/____