

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original, properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Controlled Drug? YES NO

Dose: _____ Method/Route: _____

Time of Administration: _____ If PRN, frequency: _____

Medication shall be administered: Start Date: ___/___/___ to End Date: ___/___/___

Relevant Side Effects of Medication: _____ None Expected

ALLERGIES: YES NO (specify): _____

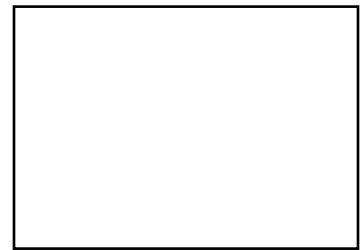
Prescriber's Name/Title: _____

(Type or print)

Phone: _____ Fax: _____

Address: _____

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. 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. The school nurse may exchange information with the prescriber to ensure safe administration of the medication.

Parent/Guardian Signature: _____ Date: _____

Parent's Phone: _____ Alternate Phone: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the nurse in accordance with 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