



STUDENT NAME [FIRST & LAST]

DOB

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Suffield Academy's preferred 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 packed in individual dosing packs. Partner's Pharmacy automatically packages medications in individual dosing packaging and will deliver them to school. They 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 individual dosing packs 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