TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION OF PARENT OR GUARDIAN FOR

ADMINISTRATION OF MEDICATION BY QUALIFIED PERSONNEL IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other qualified trained school personnel.

Name of Student_____ Date of Birth_____

School_____ Grade_____

Medication_____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber. _____

I hereby give permission for qualified trained personnel to administer this medication to my child. _____

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of this medication order in school. _____

I understand that this medication will be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first. _____

_____ _____ _____

Date Signature of Parent or Guardian Telephone

_____

Print Name of Parent or Guardian

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