

Windsor Locks Public Schools—Health Offices

() Windsor Locks High School/Pine Meadow Academy

High Sch. Nurse: Ph. 860-292-5729

Fax: 860-292-5039

Pine Meadow Nurse: Ph. 860-292-6060

Fax: 860-292-5017

() Windsor Locks Middle School Ph. 860-292-5016

Fax: 860-292-5017

() South Elementary School Ph. 860-292-5023

Fax: 860-292-5026

() North Street School Ph. 860-292-5029

Fax: 860-292-8191

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, (physician, dentist, optometrist, advanced practice registered nurse or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) 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: _____

Name and Generic name of Drug: _____

Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (specify): _____

Medication shall be administered from: _____ to _____

(Month / Day / Year)

(Month / Day / Year)

Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ 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 and I give permission for the exchange of information between the prescriber and the school nurse 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. 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.

SPECIAL INSTRUCTIONS: Please circle

1. **Late arrival:** give AM dose on arrival omit AM dose

3. **Field trips:** give as usual omit dose(s)

Print Name: _____ Signature _____

Relationship to student: _____ Date: _____

Parent's Home Phone #: _____ Cell # _____ Work # _____

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 school nurse in accordance with Board policy. In the case of inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

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 _____