AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

DARIEN PUBLIC SCHOOLS

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

Section A: Prescriber's Authorization

Student: Date of Birth:

Address:

Allergies: NO ☐ YES (specify):

Medication 1 Name: Dose: Route:

Time of Administration: If PRN, frequency:

Relevant Side effects to be observed, if any:

Condition for which drug is being administered:

Medication 2 Name: Dose: Route:

Time of Administration: If PRN, frequency:

Relevant Side effects to be observed, if any:

Condition for which drug is being administered:

Medication 3 Name: Dose: Route:

Time of Administration: If PRN, frequency:

Relevant Side effects to be observed, if any:

Condition for which drug is being administered:

Medications may be administered from: *Month/Day/Year*: *to*: *Month/Day/Year*:

Prescribers Name/Title (*type or print*):

Address:

Telephone: Fax:

Prescriber's stamp

Prescriber's signature: *Date*

Section B: Self-Administration and/or Self-Possession of Medication Authorization / Approval

Self Administration and/or self-possession of the above ordered medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with the Board Policy

Prescriber's authorization for self-administration and/or self-possession of medication Yes: ☐ No: ☐ *Signature* *Date*

Parent/Guardian authorization for self-administration an/or self - possession of medication: Yes: ☐ No: ☐ *Signature* *Date*

School Nurse Approval for self-administration and/or self-possession of medication: Yes: ☐ No: ☐ *Signature* *Date*