

School District: _____ School: _____ Grade: _____

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, advanced practice registered nurse, or physician's assistant) 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: _____ 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

Field Trip Day or Shortened Day Session: GIVE ___ OMIT ___ (please check one)

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ Fax: _____

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 45 day 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.

Parent/Guardian Signature: _____ Date: _____

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

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.

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