

Mansfield Middle School

Grade _____

Authorization for the Administration of Medicine by School Personnel-Field Trip Form

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized health care provider (physician, dentist, advanced practice nurse, or physician assistant) and parent/guardian written authorization for the nurse, or in the absence of a nurse, a designated principal or teacher to administer medication. Medication must be in pharmacy prepared containers and properly labeled with the child's name, drug name and strength, dosage, frequency, provider's name, and date of original prescription. The medication must be brought to the school by a parent/guardian or responsible adult.

Health Care Provider's Authorization

Name of student: _____ Date of Birth: _____

Address: _____

#1. Condition for which drug is being administered: _____ Drug name: _____

Dose: _____ Route: _____ Time(s) of administration: _____

If PRN, frequency: _____ Relevant side effects: _____

If there are side effects, plan for management: _____

Medication shall be administered from (m/d/yr): _____ to (m/d/yr) _____

Is this a controlled drug? Yes ___ No ___. If Yes, please include DEA number: _____

#2. Condition for which drug is being administered: _____ Drug name: _____

Dose: _____ Route: _____ Time(s) of administration: _____

If PRN, frequency: _____ Relevant side effects: _____

If there are side effects, plan for management: _____

Medication shall be administered from (m/d/yr): _____ to (m/d/yr) _____

Is this a controlled drug? Yes ___ No ___. If Yes, please include DEA number: _____

The medications above may be self-administered by this student

Prescriber's Stamp

Health Provider's Name/Title _____

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____

Parent/Guardian Authorization

I hereby request that school personnel administer the above ordered medication(s). I understand that I must provide the school with no more than the required amount of medication in a pharmacy prepared container and properly labeled with my child's name, drug name and strength, dose, frequency, provider's name and date of original prescription. The medication must be brought in by the parent/guardian or responsible adult. I understand that the medication will be destroyed if not picked up within one week following termination of the order.

The medications above may be self-administered by my child.

My child will not require any medication on this trip.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Home phone number: _____ Cell : _____ Work : _____