

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 health care provider (physician, dentist, advanced practice registered nurse, or physician's assistant) and parent/guardian written authorization for the nurse, or in the absence of a nurse, a designated principal or teacher to administer medication. **Medications must be in pharmacy prepared containers and properly labeled with 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 or responsible adult.**

Health Care Provider's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Medication Allergies No Yes _____

Condition for which drug is being administered: _____ Drug Name: _____

Dose: _____ Route: _____ Time of Administration: _____

If PRN, frequency: _____ Relevant side effects: None expected Specify: _____

If there are side effects, plan for management: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

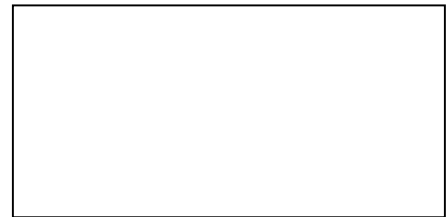
Is this a controlled drug? Yes No If yes, please include DEA number: _____

Health Provider's Name/Title _____

Telephone: _____ Fax: _____

Address: _____

***Prescriber Signature:** _____ **Date:** _____



Use for Prescriber Stamp

Parent/Guardian Authorization

I hereby request that school personnel administer the above ordered medication. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that the medication will be destroyed if not picked up within one week following termination of the order or one week beyond the close of school.

***Parent/Guardian Signature:** _____ **Date:** _____

Home phone number: _____ Work number: _____ Fax number: _____

Self-Administration of Medication Authorization/Approval

Self-administration of medication may be authorized by the prescriber and the parent/guardian and must be approved by the school nurse in accordance with Board policy. **For example, asthma inhalers and Epi-pens for sting or nut allergies may be self-carried. Other medications require the consent of the medical advisor.**

Prescriber 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