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

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. 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. If my child is also enrolled at a school-based clinic in this school, I hereby give permission to both the school nurse and the school-based clinic to share this information and otherwise collaborate in the management of this problem for my child.

Parent/Guardian Signature:_____ Date:_____

Parent's Home Phone #:_____ 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.

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

SRC-1, Rev 1/01