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, optometrist, advanced practice registered nurse, physician's assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal, teacher or other qualified personnel 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:_____

Address:_____ Date of Birth:_____

Condition for which drug is being administered:_____

Drug name:_____ Generic name:_____Dose:_____Route:_____

Time of Administration: _____If PRN, frequency:_____

Relevant side effects to be observed, if any:_____

If there are side effects, Plan of Management:_____

Is this a controlled drug? _____ If yes, DEA number: _____

Drug to be administered FROM:_____ TO _____
(up to 12 months from July 1 to June 30) (Date) (Date)

Field Trip Day or Shortened Day Session: GIVE_____ OMIT_____ (please check one)

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

Telephone:_____ Fax:_____

Address:_____
_____

Prescriber's Signature:_____ Date:_____

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 three month 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. I also understand that I am giving permission for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of such medication.

Parent Signature:_____ Date:_____

Parent's Home Phone #:_____ Work #_____

SEE REVERSE SIDE FOR SELF ADMINISTRATION

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a verified chronic medical condition, self administration of emergency medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to Connecticut State Regulations, Section 10-212a-4, and in accordance with Board policy.

Please indicate:

_____Rescue Asthma Inhaler

_____Cartridge Injector for Medically Diagnosed Allergies

_____ Insulin by Insulin Pump or Injection

Prescriber's Authorization:

It is my opinion that _____has sufficient knowledge and understanding of his/her medication to warrant permission to carry and to self administer this medication during school hours, on a field trip, before and after school programs and athletic events.

_____ _____

Physician Signature Date

Parent/Guardian Authorization:

I give my son/daughter_____permission to self administer his/her medication during school hours, on a field trip, before and after school programs and athletic events.

_____ _____

Parent/Guardian Signature Date

School Nurse Review: Date_____

Comments:

Approved: _____ Date _____
Denied: _____ Date _____
Not Required: _____ Date _____

_____ _____

School Nurse Signature Date