

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 or 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, designated qualified personnel to administer medication. Medications must be brought in the original properly labeled container and dispensed by a physician/pharmacist.

**PRESCRIBER'S AUTHORIZATION/MEDICATION PLAN**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

ALLERGIES:  NO  YES (specify) \_\_\_\_\_

Condition(s) for which drug(s) is being administered: \_\_\_\_\_

Drug and Generic Name (Both required by State of CT): \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time of administration: \_\_\_\_\_ If PRN, Frequency \_\_\_\_\_

Relevant side effect:  None expected  Specify: \_\_\_\_\_

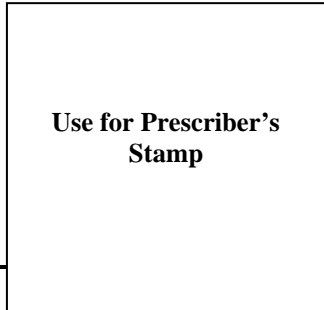
\*If permitted to self administer medication, please note below.

Medication(s) shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Prescriber's Name/Title \_\_\_\_\_  
(Type or print)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**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 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of order or end of school. I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of such medication. I understand how each of the above medication is to be administered including the condition, dosage, time frequency, route and relevant side effects.

Please check appropriate box and sign:

Please administer the above medication on days with: Early Dismissal:  YES  NO Late Arrival:  YES  NO  
Field Trips:  YES  NO Overnight Trips:  YES  NO

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*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