AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law and Regulations require an authorized prescriber’s (physician, dentist, optometrist, advanced practice registered nurse, or physician’s assistant and for interscholastic and intramural athletic events only, a podiatrist) written order and parent or guardian’s authorization for a nurse to administer medications or, in the absence of the nurse, qualified school personnel to administer medications. Medications must be in the original properly labeled container and dispensed by a physician or pharmacist.

PRESCRIBER’S AUTHORIZATION

Name of Student: ____________________________________________________________ Date of Birth: __________

Condition for which drug is being administered: ________________________________________________________________

Drug/generic name: __________________________ Dose: __________________ Route: _________________________________

Time of administration: ________________________________ Frequency, if PRN: _________________________________

Relevant side effects: [ ] None expected [ ] Yes (Specify): ______________________________________________________

ALLERGIES: [ ] NO [ ] YES (Specify): ________________________________

Medication shall be administered from (date) __________________________ to (date) __________________________

Medication needed for Field Trip: _______yes______no Medication to be given on half day: _____ yes _____ no

Prescriber’s Name/Title: __________________________ Phone #: __________ Fax #: __________

Address: _____________________________________________________________________________________________

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 3 month supply of medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school, whichever comes first. I grant permission for the school nurse to exchange information with this prescriber regarding the administration of this medication.

Parent/Guardian’s Signature: __________________________ Date: ______________________________

Telephone (home) __________________________ (work) __________________________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of a medication may be authorized by the prescriber and parent/guardian for certain medications. Authorization must be presented to the school nurse in accordance with Board policy and district nursing protocols.

Prescriber’s authorization for self-administration: [ ] Yes [ ] No __________________________ Date: __________ (signature)

Parent/Guardian authorization for self administration:[ ] Yes [ ] No __________________________ Date: __________ (signature)

School nurse approve for self administration (not required for inhalers or cartridge injectors) [ ] Yes [ ] No __________________________ Date: __________ (signature)

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