

School District: _____ School: _____ Grade: _____

Authorization for the Administration of Medicine by Authorized 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, qualified personnel for schools to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Authorized 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): _____

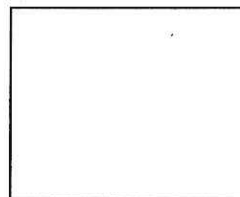
Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

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

Telephone: _____ Fax: _____

Address: _____

Authorized Prescriber's
Signature: _____ Date: _____



Use for Authorized 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 three (3) month supply of medication. I understand that this medication will be destroyed if not picked within one (1) week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's/Guardian's Home Phone #: _____ Work #: _____

Self-Administration of Medication Authorization/Approval

Self-administration of medication may be authorized by the authorized prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

Authorized 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