

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

Field Trip Day or Shortened Day Session: GIVE \_\_\_ OMIT \_\_\_ (please check one)

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

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

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.*

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

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

**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