AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations requires a physician's, physician's assistant's, A.P.R.N.'s or dentist's written order and parent/guardian's authorization for a nurse to administer medications or, in her absence, the principal or teacher to administer medications. Medications must be in a pharmacy prepared container and labeled with the child's name, drug name, strength, dosage, frequency, prescriber's name and date of original prescription.

ORDER:

Student's Name:_____ Date:_____

Address:_____ Date of Birth:_____

Condition for which medicine is being administered:_____

Name of Drug:_____ Amount of drug:_____

Time of Administration:_____ Frequency:_____

Route:_____

Relevant side effects to be observed, if any:_____

If there are side effects, plan for management:_____
Length of time medication shall be administered (note may not exceed one school year)

From:_____ to_____

Is this a controlled drug? ( )yes ( )no If yes, DEA number_____

Please check ( ) Physician/ Physician Assistant ( ) * A.P.R.N.* ( ) Dentist

_____ _____ _____

(name: type or print) (address) *(and office affiliation) (date signed)

Signature:_____

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.AUTHORIZATION BY PARENT/ GUARDIAN for administration of above medication by school personnel.

To: _____ Date:_____
(name of school)

I hereby request the school give my child_____ the medication ordered above. I realize it is my responsibility to supply the medication to the school in an amount not to exceed 45 days. I understand that students may not transport medication to or from school/ School Nurse Office. Parent/ guardian must bring directly.

PARENT/GUARDIAN SIGNATURE: _____

ADDRESS: _____ TELEPHONE_____

ALL MEDICATIONS THAT ARE LEFT MUST BE PICKED UP BY THE LAST DAY OF SCHOOL OR WE ARE REQUIRED TO DISCARD THEM.