

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL**

Connecticut State Law and Regulations 10-212(a) require a physician's or dentist's written order and parent/ guardian written authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Medicinal preparations shall not include hallucinogenic or narcotic drugs per Board of Education Policy.

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**PRESCRIBER'S AUTHORIZATION**

Date \_\_\_\_\_

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

Address: \_\_\_\_\_

Condition for which drug is being administered during school hours: \_\_\_\_\_

Drug name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

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

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

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

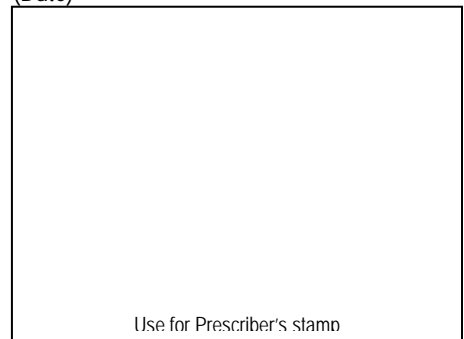
Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date)

Prescriber's Name/Title: \_\_\_\_\_

Telephone #: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

Prescriber's 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

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**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 the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 90 school day supply of said 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 #: \_\_\_\_\_