

**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

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

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

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

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 #: \_\_\_\_\_

**SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

*Self-administration of medication may be authorized by the prescriber and the parent/guardian and must be approved by the school nurse in accordance with Board policy. **For example asthma inhalers and Epipen for bee or nut allergies may be self carried. Other medications require the consent of the medical advisor.***

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