

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a written order from a licensed physician, dentist, an advanced practice R.N. or a physician's assistant; and a parent or guardian's written authorization for a nurse to administer medications or, in her absence, the principal or teacher. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's name or name of ordering practitioner and date of original prescription.

LICENSED PHYSICIAN/DENTIST'S ORDER, ADVANCED PRACTICE R.N., OR PHYSICIAN'S ASSISTANT

Name of Child _____ Date _____

Address _____ Date of Birth _____

Condition for which drug is being administered _____

(If Asthma is diagnosed please indicate classification mild moderate severe exercise induced unclassified)

DRUG: name, dose and method of administration _____

Time of administration in school _____

Time & dosage of this medication given at home daily/field trips _____

Child may self-administer medications on field trip yes no

Child may self-administer medications in school yes no

Medication shall be administered from _____ to _____
(New Administration of Medication form required after one year from above date) (Date) (Date)

Relevant side effects/plan for management _____

Is this controlled drug? _____ if yes, DEA number _____

Physician/Advanced Practice R.N./
Licensed Physician's Assistant/Dentist's Name _____
(Signature) (Type or Print Name)

Address _____ Tel: _____
Date: _____

AUTHORIZATION BY PARENT/GUARDIAN for the above medication by school personnel:

I hereby request that the above medication, ordered by the Physician/Advanced Practice R.N./licensed Physician's Assistant/Dentist for my child _____ be administered by school personnel. I am aware 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 45 school day supply of said medication. I also understand that refills of the prescription must come from the pharmacy with proper labeling and I am NOT authorized to fill pharmacy bottles with prescribed medication remaining from a prior prescription. I am aware that this medication (other than controlled drugs) will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school. I also give my permission for the school nurse to contact the above medical personnel in regards to questions that may arise regarding the administration of the above medication. If medication is discontinued or changed I will secure a discontinue/change order from the physician. Pertinent medical information will be shared with other school related personnel on a "need to know" basis to provide a continuum of care. Please keep the school nurse updated with any changes in your child's health status.

Parent/Guardian Signature

Date

Home Phone _____ Work Phone _____ Cell Phone _____