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, teacher and/or coach 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: _________________________________________________

Prescriber’s Name/Title

(Type or print) ___________________________

Telephone: ___________________________ Fax: ___________________________

Address: __________________________________________________________________________

Prescriber’s Signature: ___________________________ Date: ____________

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 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 parent/guardian and must be approved by the school nurse in accordance with Board policy.

Prescriber’s authorization for self administration: ______ Yes ______ No ______

Parent/Guardian authorization for self administration: ______ Yes ______ No ______

School nurse approval for self administration: ______ Yes ______ No ______

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