Saint Mary School

School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from 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, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name/ Strength _____ 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 and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 90 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 #: _____

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips

I DO / DO NOT wish medication ADMINISTERED on shortened days _____ _____
Signature Date

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication (inhalers, EpiPens or other medications approved by the School Medical Advisor and Head Nurse) may be authorized for middle and high school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and 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

Received by _____ Date of Receipt/Form _____ Date of Receipt/Medication