Stonington Public Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-21(a) 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. 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 Brand Name: ______________ Drug Generic Name: ______________

Drug Dose: ______________ Drug 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

Is this a controlled drug? ______________

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 the prescribed medication in the original container dispersed and properly labeled by a physician or pharmacist. I will provide no more than a three month supply of the medication. I understand that this medication will be destroyed, if it is not picked up within one week following termination of the order or beyond the close of school. **I consent to communication between the school nurse and prescriber regarding any questions with this medication.**

Parent/Guardian Signature: ______________ Date: __________

Parent's Home Phone #: ______________ Work#: __________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Students may self administer and carry medication (no controlled drugs) according to Stonington Public Schools policies.

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

7/14/2011