# 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