AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Staff will not administer any medications except Epi-pen for unknown emergency allergic reactions.

Connecticut State Statute and regulations require a physician's or dentist's written order and parent's or guardian’s authorization for school personnel to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, physician's or dentist’s name and date of original prescription. No more than 90 days supply should be brought in by the parent/guardian and given to the nurse.

PHYSICIAN OR DENTIST ORDER

Name of Student____________________________________________________Date__________________________
Address____________________________________________________________Date of Birth___________________
Condition for which the drug is being administered during school hours__________________________________________
________________________________________________________________________________________________
Drug: Name, Dose and method of administration_________________________________________________________
________________________________________________________________________________________________
Time of administration ____________________________________________
Medication should be administered from (date)________________________to (date)__________________________Allergies________________________________________________________
May medication be self-administered by student under nurse’s supervision Yes ________ No_______
Relevant side effects to be observed, if any___________________________________
If there are side effects, plan for management_________________________________________________________
Is this a controlled drug?____________________ If yes, DEA number________________________________________
This medication should be administered during FIELD TRIPS? YES________ NO_________
This medication should be administered on SHORTENED SCHOOL DAYS? YES________ NO_________
Physician Office Stamp

Physician/Dentist Signature__________________________________________________________Date_______________
Nurse Signature ___________________________________________________________________Date_______________

AUTHORIZED BY PARENT/GUARDIAN for the administration of the above medication by school personnel:

Date________________________________________

To School Personnel:
I hereby request that school personnel administer the above medication, ordered by the physician/dentist for my child. I understand that I must supply the school with the following:

• Written order from physician/dentist
• Signed permission from parent
• Parent/adult must deliver medication to school
• Medication must be in original container and properly labeled
• Bring only 90 days of supply or less of medication

I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.

I request that this medication be given on field trips as needed by school personnel.

Name__________________________________________________________ Relationship to Child____________________________
(Print)

Signature____________________________________ Home Phone________________________________________
Address____________________________________ Work Phone________________________________________

6/20/11