REGION 12 SCHOOL DISTRICT

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order by an authorized prescriber (physician, dentist, advanced practice registered nurse, or physician's assistant) and parent/guardian written authorization for the school 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 dispensed by the physician/pharmacist. Over the counter medications must be in the original, unopened container.

Prescriber's Authorization

Name of Student _____Date of Birth _____Grade _____

Address_____

Condition for which drug is being administered _____

Drug Name _____ Generic Name _____Dose _____Route _____

Time of Administration _____If PRN, frequency _____

Relevant side effects: ☐ None expected ☐ Specify _____

ALLERGIES: ☐ No ☐ Yes Specify_____

Medication shall be administered from (up to one year): Specify dates _____ to _____

Prescriber's Name/Title Printed _____

Telephone _____ Fax_____

Address _____

Prescriber's Signature _____Date _____ Use for Provider's Stamp

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered to my child by school personnel. I consent to communications between the school nurse and the prescriber regarding any issues with the above named medication. I understand that a parent/guardian or a responsible adult must deliver the medication to the school nurse. I understand that the medication must be retrieved by a responsible adult when the order expires and/or the school year ends (within one week) or the medication will be discarded.

Parent/Guardian Signature _____ Date _____

Telephone: Home # _____ Work # _____ Cell # _____

Authorization/Approval for Self Administration of Medication

A responsible student will be allowed to carry and self-administer medication with the approval and authorization of the licensed prescriber, the parent/guardian, and the school nurse in accordance with Board Policy.

Prescriber's authorization for self-administration (signature) _____ Date _____

Parent/Guardian authorization for self-administration (signature) _____Date_____

School Nurse approval for self-administration (signature) _____ Date_____

4/2016 EMP