

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 communication between the school nurse and the prescriber regarding any issues with the above named medication. I understand that I must supply the school with no more than three months supply of 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 _____