School District ________ School ______________________________ Grade ____________

## SCHOOL MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of 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. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 201 -201

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

## Prescriber's Authorization

**Name of Student** ______________________________ **Date of Birth** ____________

**Condition for which medication is administered** ____________________ **Medication Allergies** ☐ NKDA ☐ Yes: ____________

**Medication** ____________________ **Dose:** ________ ☐mg ☐puffs ☐amp ☐other **Route:** ☐PO ☐GT / NGT ☐Inhaled ☐with Spacer

**Time of Administration** __________ ☐AM ☐PM

**If PRN, frequency, Q** ______ Hours

**Provider Name & Phone/fax Numbers (printed or stamped)**

**Prescriber's Authorization for Self-Administration** ☐ Yes ☐ No

**Prescriber's Signature** ____________________ **Date:** ________

## 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 no more than a 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following discontinuation of the medication or the last day of school, whichever comes **first.**

I also authorize communication between the prescribing health care provider and school nurse necessary for the safe administration of this medication and the management of the condition for which it is prescribed.

**Parent/Guardian Authorization for Self-Administration** ☐ Yes ☐ No

Parent/Guardian Signature: ____________________ Date: ____________

Parent's Home Phone# Work/ Cell #

Signature Date