Ansonia School District

School: _____ Teacher Name_____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212 require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse, or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) 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: _____

Condition for which drug is being administered: _____

Drug/generic name: _____ Dose: _____ Route: _____

Time of administration: _____ Frequency, if PRN: _____

Relevant side effects: [ ] None expected [ ] Yes (Specify): _____

ALLERGIES: [ ] NO [ ] YES (Specify): _____

Medication shall be administered from (date) _____ to (date) _____

Medication needed for: Field Trip: [ ] yes [ ] no Given on half day: [ ] yes [ ] no Given on delayed day: [ ] yes [ ] no

Prescriber's Name/Title: _____

Phone #: _____ Fax #: _____

Address: _____

Signature: _____ Date: _____ Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian's Signature: _____ Date: _____

Phone Number (home) _____ (cell) _____ (work) _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of a medication may be authorized by the prescriber, parent/guardian, and must be approved by the school nurse in accordance with Board policy. In the case of inhalers for asthma and cartridge injectors for medically diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent/guardian or eligible student.

Prescriber's authorization for self-administration: [ ] Yes [ ] No _____ Date: _____

Parent/Guardian authorization for self-administration: [ ] Yes [ ] No _____ Date: _____

School nurse approve for self-administration [ ] Yes [ ] No _____ Date: _____