

Stratford Public Schools Stratford, Connecticut

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) and Board of Education policy require the following:

1. - A written medication order from a licensed Medical Doctor (MD), Osteopathic Doctor (OD), Dentist (DMD or DDS), Advanced Practice Registered Nurse (APRN) or Physical Assistant for prescription and "over-the-counter" (nonprescription) medication which needs to be given in school.
2. - Written parental/guardian consent for medication administration in school.
3. - Delivery of medication to the school nurse by a responsible adult, preferably the parent/guardian.
4. - medication in the original container with proper labeling (name of medication, student's name, dosage and frequency of administration, time or conditions of use).
5. Approval by the school nurse, in addition to written authorizations, for self-administration of medications in school.

Medical Authorization

NAME OF STUDENT _____ DOB _____

MEDICATION NAME DOSAGE _____

ROUTE OF ADMINISTRATION _____

FREQUENCY/CONDITIONS OF USE _____

SIDE EFFECTS TO BE NOTED AND MANAGEMENT PLAN _____

MEDICATION TO BE ADMINISTERED -

FROM (DATE) _____ TO (DATE) _____

Permission to give in school if dose missed at home (Please circle one) Yes No

Student may self-administer medication with supervision
(Please circle one) Yes No

Students may self-administer medication without supervision after the school nurse has confirmed that the student knows the indications for medication and proper administration techniques. (Please circle one.) Yes No

PRESCRIBER'S NAME/TITLE _____

PHONE ADDRESS OF PRESCRIBER _____

PRESCRIBER'S SIGNATURE/ DATE _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above-ordered medication be administered by school personnel.
2. I understand that I may bring only a 45-day supply of medication to school, and it is my responsibility to pick up the medication at the end of the school year or within one week following the termination of the medical order.
3. I would or would not like this medication to be administered on field trips or early dismissal days.

PARENT/GUARDIAN NAME: _____

Phone (cell) _____

PARENT/GUARDIAN SIGNATURE _____