**2020 - 2021 School Year**

|  |  |  |  |
| --- | --- | --- | --- |
| **School:** |  | **Grade:** |  |

# AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

**Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a9 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician’s assistant, optometrist and, for athletic events only, a podiartist) and parent/guardian written authorization, for school nurses, or in the absence of a nurse, other designated personnel to administer medication, including over-the-counter drugs. Medications must be in the original, properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container. ALL medications must be delivered to school by a responsible adult.**

## Prescriber’s Authorization

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Student:** |  | **Date of Birth:** |  |

|  |  |
| --- | --- |
| **Address:** |  |

|  |  |
| --- | --- |
| **Indication(s) for medication** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:** |  | **to** |  |
| **(up to 12 months)** | **Month / Day / Year** |  | **Month / Day / Year** |

|  |  |
| --- | --- |
| **Prescriber’s Name/Title:** |  |
|  | **(*type or print*)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Telephone:** |  | **Fax:** |  |

|  |  |
| --- | --- |
| **Address:** |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Prescriber’s Signature:** |  | **Date:** |  |

**Use for Prescriber’s Stamp**

# PARENT/GUARDIAN AUTHORIZATION

***I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 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, unless the student will be attending an extended school year (ESY) program.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Parent/Guardian Signature:** | |  | | | **Date:** |  |
| **Parent’s Home Phone #:** |  | | **Work #:** |  | | |

### SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

***For capable students with a chronic medical condition, self-administration of emergency and some other non-controlled medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-4, and Board policy.***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Prescriber’s authorization for self administration:** | | |  | | **Yes** | |  | | **No** | |  | |  | |
|  | | |  | |  | |  | |  | |  | |  | |
|  | | |  | |  | |  | |  | | **Signature** | | **Date** | |
| **Parent/Guardian authorization for self administration:** | | | |  | | **Yes** | |  | | **No** | |  | |  | |
|  | | | |  | |  | |  | |  | |  | |  | |
|  | | | |  | |  | |  | |  | | **Signature** | | **Date** | |
| **School nurse approval for self administration:** |  | **NR\*** |  | | **Yes** | |  | | **No** | |  | |  | |
|  |  |  |  | |  | |  | |  | | **Signature** | | **Date** | |

#### \*NR means *not required*

SCHOOL HEALTH SERVICES

**2020 - 2021 School Year**

Health Office – (203)

### PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

**If your child requires a prescription or over-the-counter medication during the school day or during intramural or interscholastic athletic events, you must follow the procedures required by** **, Connecticut General Statutes, Sec. 10-212a, and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-9. These procedures promote safe practices for students and staff. Please read them carefully.**

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist¸ advanced practice registered nurse, physician assistant or optometrist) using  form, *Authorization for the Administration of Medicine by School Personnel* (see over). A new order is required each year.
2. The authorized prescriber must fill in the information requested on the form:
3. Name of medication, the generic name of the medication (NEW), and strength of the medication;
4. Indication(s) for the administration of this medication in school (condition, diagnosis);
5. Amount (dosage) of the medication to be administered and route of administration
6. Potential side effects of the medication;
7. Time of day that the medication is to be administered; and frequency for PRN (as-needed) medications
8. Duration of the order for administration of the medication (up to 12 months).
9. If applicable, authorization for self-administration in school.
10. A parent or guardian must sign the “Parent/Guardian Authorization” portion of the form and, if applicable, provide authorization for self-administration in school.
11. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student’s name, the authorized prescriber’s name, and the prescription.
12. The medication and completed authorization form **must be delivered to the school nurse by a responsible adult**, except that, once the nurse has reviewed the medical order and developed a plan for self-administration, the student is responsible to carry the medication to/from school each day and maintain its safe control at all times.
13. Self administration plans approved for the school day also extend to extra curricular activities and athletics.
14. Self administration of controlled medication is not permitted.
15. No more than a three (3) month supply may be stored at school. Except for students attending an ESY program, **unused medication must be destroyed** if not picked up by a responsible adult by the end of the last day of school.

It may be helpful to take this authorization form (side one) with you to your healthcare provider in case medication is prescribed for your child.

Thank you for your cooperation. Please contact the school nurse if you have any questions.

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#### Record of medication received

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| --- | --- | --- | --- |
| DATE | COUNT | PARENT/ADULT SIGNATURE | SCHOOL NURSE SIGNATURE |
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