

# Stonington Public Schools

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-21(a) require a written medication order from 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 and dispensed by a physician/pharmacist.

### PRESCRIBER'S AUTHORIZATION

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Condition for which drug is being administered: \_\_\_\_\_

Drug Brand Name: \_\_\_\_\_ Drug Generic Name: \_\_\_\_\_

Drug Dose: \_\_\_\_\_ Drug Route: \_\_\_\_\_

Time of Administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

Relevant side effects:  None expected  Specify: \_\_\_\_\_

ALLERGIES:  NO  YES Specify: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

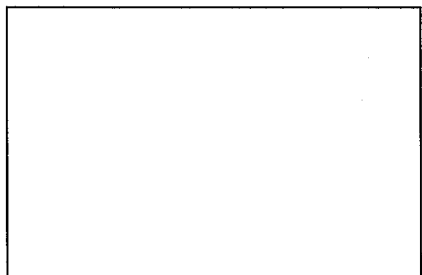
Is this a controlled drug? \_\_\_\_\_

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. I understand that I must supply the school with the prescribed medication in the original container dispersed and properly labeled by a physician or pharmacist. I will provide no more than a three month supply of the medication. I understand that this medication will be destroyed, if it is not picked up within one week following termination of the order or beyond the close of school. I consent to communication between the school nurse and prescriber regarding any questions with this medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone #: \_\_\_\_\_ Work#: \_\_\_\_\_

### SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Students may self administer and carry medication (no controlled drugs) according to Stonington Public Schools policies.

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:  Yes  No \_\_\_\_\_  
Signature Date