Griswold Elementary School: 303 Slater Ave Griswold, CT 06351 **Telephone**: 860-376-7615 **Fax**: 860-376-7612
Griswold Middle School: 211 Slater Ave Griswold, CT 06351 **Telephone**: 860-376-7324 **Fax**: 860-376-7631
Griswold High School: 267 Slater Ave Griswold, CT 06351 **Telephone**: 860-376-7647 **Fax:** 860-376-7677

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations10-212 (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 and dispensed by a physician/pharmacist.

Prescriber Authorization

Name of Student:____ Date of Birth:__________

Address: ____

Condition for which drug is being administered:____

Drug Name: ______________________________Dose: ____________________Route:________

Time of Administration: ________________________________ If PRN, frequency:_____________

Relevant side effect: ☐ None expected ☐ Specify:____

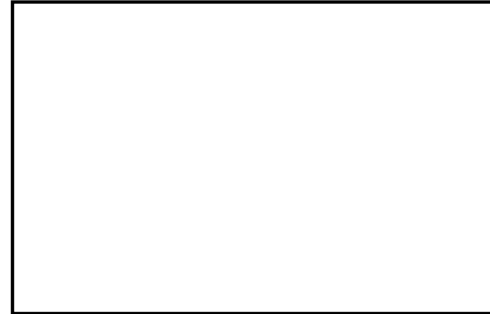
ALLERGIES: ☐ NO ☐ YES (*specify*):____

Medication shall be administered from: ____________________ to ___________________________
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. I understand that I must supply the school with no more than a 3 months supply of medication. I understand that this medication needs to be picked up within one week following termination of the order or the last day of school, whichever comes first. **I give permission for necessary information to be exchanged between the Prescriber and the school nurse to ensure the safe administration of this medication.**

Parent/Guardian Signature:____Date:____________

Parent's Home Phone#: ____________________Cell#: ____________________ Work#:___________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

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 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