Authorization for the Administration of Medication by School Personnel

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In Connecticut schools, administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations (Sec. 10-212a-4) and Board Policy. Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Name of Child/Student_____ Date of Birth __/__ /__ Today's Date__ /__/__

Address of Child/Student_____ Town _____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES__ NO__

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date__: /___/__ End Date: __ / ___/__

Relevant Side Effects of Medication_____ None Expected__

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title_____ Phone Number (___) _____

Prescriber's Address _____Town _____

Prescriber's Authorization and Signature: _____Date: _____

Parent/Guardian Authorization:

___I request that medication be administered to my child/student as described and directed above

___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 (RN) necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a t (3) month supply of medication.

Parent/Guardian Signature_____ Relationship _____Date__ /___/__

E-mail: _____Cell Phone # (___) ___ -____ Other Phone # (___) -___-____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are **six** years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. **Student to self-administer medication: _____YES _____NO**
2. Student to possess medication: _____YES_____NO

Prescriber's Authorization and Signature: _____Date: _____

Parent/Guardian Signature_____Date_____

School nurse (**RN**) Approval of self-administration (if applicable): _____Date: _____