

MILFORD SCHOOL HEALTH SERVICES

School District: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**

*Connecticut State Law and Regulations 10-212(a)1 THROUGH 10-212(A)6 require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician's assistant, optometrist and, for athletic events only, a podiatrist) and parent/guardian written authorization, for school nurses, or in the absence of the 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): \_\_\_\_\_

Medications shall be administered from: \_\_\_\_\_ to \_\_\_\_\_

(Up to 12 months from July 1 to June 30) Month/Day/Year

Month/Day/Year

Prescriber's Name/Title: \_\_\_\_\_

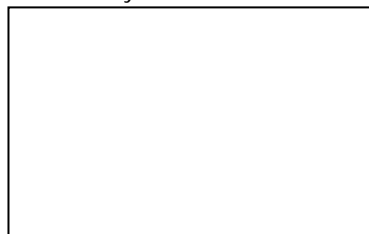
(Type or print)

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

Received by: \_\_\_\_\_ Date of Receipt: \_\_\_\_\_

\*NR—NOT REQUIRED