<u>Thomaston Public Schools</u>
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-12(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. The school nurse has permission to exchange information with the prescriber necessary to ensure the safe administration of this medication.

Prescriber's 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 effects: ☐ *None expected* ☐ *Specify:* _____

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

Medication shall be administered from: _____ to _____
                                                    Month / Day / Year   ***Month / Day / Year***

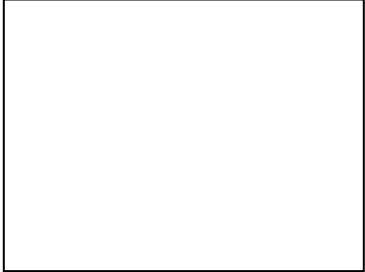Prescriber's Name/Title: _____
                                     (*Type or print*)

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 90-day 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. I give permission for the school nurse to discuss medical information with the prescribing physician.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Home Phone #: (_____)_____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'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

Today's Date _____Printed Name of Person Receiving Form and Medication _____

Title/Position _____ Signature _____