

Thomaston Public Schools

Authorization for the Administration of Medicines By School Personnel

Connecticut State Law and Regulations 10-21 (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's Authorization

Name of Student _____ DOB _____

Address _____ Phone _____

Condition for which drug is being administered during school hours _____

Drug Name _____ Dose _____ Route: _____

Time of Administration _____ If PRN, Frequency: _____

Relevant side effects _____ None Specify: _____

Medication will be administered from _____ to _____

ALLERGIES ___No ___Yes (specify) _____

Prescriber's Name/Title: _____
type or print

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature _____ Date _____

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 45 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.

Parent/Guardian Signature _____ Date: _____

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