

USE FOR ALL GRADES

School: The Country School  
Academic Year: 2010-2011  
Grade: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
School Nurse Initials: \_\_\_\_\_

**AUTHORIZATION FOR ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL**

Connecticut State Law\* & Regulations require a physician/dentist/APRN/PA'S written order and a parent/guardian's signature for a school nurse (or in her absence the principal or authorized teacher) to administer medications. \*(General Statutes, Section 10-212a PHN-85 (6-71)3M, CT State Department of Health).

*Medication must be received in pharmacy prepared containers, labeled with the student's name, name of drug, strength, dosage, frequency, physician/prescribing provider/dentist's name and date of original prescription. Parent/guardian or responsible adult must deliver the medication, limited to a 45 day supply.*

**LICENSED PRESCRIBING PROVIDER'S ORDER**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Condition for which drug is being administered: \_\_\_\_\_

Name of drug, dose, method of administration and frequency of administration: \_\_\_\_\_

THIS IS A NOT CONTROLLED DRUG     THIS IS A CONTROLLED DRUG

Time of Administration: \_\_\_\_\_

Duration of Order: 09/01/2010 to 06/30/2011

Relevant side effects to be observed: \_\_\_\_\_

Management Plan: \_\_\_\_\_

Signature of Physician: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's address/phone: \_\_\_\_\_

Provider stamp: \_\_\_\_\_

**SCHOOL AUTHORIZATION for student to self-administer inhaler or medication for anaphylaxis:**

Head of School \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ School RN: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Authorization of Parent/Guardian For Administration of Above Medication by School Personnel**

To: The Country School, Madison, Connecticut Date: \_\_\_\_\_

I hereby request that school personnel give my child, \_\_\_\_\_, be given the medication ordered above by our Physician. I understand that medications to be administered must be brought into school in an original over-the-counter or pharmacy container labeled with name of student, name of prescribing physician, date of original prescription, name and strength of medication, and directions for administering. No more than a 45 school day supply of medication will be kept in school. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school. I consent to communication between school nurse the above prescriber with any issues regarding this medication.

Signature of Parent/ Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_