



Overnight Medication Order

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: _____

Allergies: _____

Condition for which drug is being administered: _____

Name of drug, dose and method of administration: _____

THIS IS A NOT CONTROLLED DRUG This is a controlled drug DEA number _____

Time of Administration: _____

Duration of Order: _____

September 1, 2010 TO June 30, 2011

Relevant side effects to be observed: _____

Management Plan:

SELF ADMINISTRATION(Grades 5-8 only):

A self-reliant student will be allowed to administer an inhaler or medication for anaphylaxis, **WITH** approval of the School Nurse, MD/licensed prescribing provider, parent, and principal. *Is this student capable of self-administration of inhaler or medication for anaphylaxis?* ____ Yes ____ No

Signature of Physician: _____



Date: ____/____/20____

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

I hereby request that school personnel give my child _____ 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 or 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____