West Hartford Public Schools Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) 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: _____ **D.O.B.**_____

Address: _____ City, State, Zip_____

Condition for which drug is being administered: _____

Name and Generic name of Drug: _____

Dose: _____ **Route:** _____ **Time of Administration:** _____ **If PRN, frequency:** _____

Relevant side effects: ____None expected ____Yes 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: _____

School Nurse Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (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.

Parent/Guardian Signature: _____ Date:_____

Parent's Home Phone #: _____ **Cell #** _____ **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. In the case of inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

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