Town of Berlin School District

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: _____ Grade:_____ Date of Birth: _____

Address: _____

*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 Specify: _____

ALLERGIES: __Yes or __No (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)

School Nurse Signature: _____ Date: _____

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 # _____

E Mail address: _____

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 or __No Signature: _____ Date: _____

Parent/Guardian authorization for self-administration: __ Yes or __No Signature: _____ Date: _____

School nurse approval for self-administration: __ Yes or __No Signature: _____ Date: _____