PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a **prescription** or **over-the-counter medication** during the school day, you must follow the guidelines required by Connecticut General Statutes, Sec. 10-212a and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-10. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorization prescriber (physician, dentist, advanced practice registered nurse, ophthalmologist or physician assistant) using the Authorization for Administration of Medicine by School Personnel (see over). A new order is required each year.

2. The authorized prescriber must fill in the information requested on the form:
   a. Student name
   b. Name and generic name of medication
   c. Dosage of medication
   d. Route, time, frequency of administration
   e. Indication for medication
   f. Any potential side effects including overdose or missed dose of medication
   g. Start and termination dates not to exceed 12 month period
   h. Written signature of prescriber.

3. A parent or guardian must sign the “Parent/Guardian Authorization” portion of the form.

4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student’s name, the authorized prescriber’s name, and the prescription.

5. The medication and completed authorization form must be **DELIVERED TO THE SCHOOL NURSE BY A RESPONSIBLE ADULT**.

6. No more than a **3 month supply** may be stored at the school.

7. At the end of the school year, medications not picked up by parent or guardian will be destroyed per Sec 10-212a-5-I4i.

8. Thank you for your cooperation. Please contact the school nurse at your school if you have any question.

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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, 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: ___________________________ Date of Birth: ___________________________

Address: _____________________________________________

Condition for which drug is being administered: ___________________________________________

Drug Name: ___________________________ Dose: ___________________________ Route: ___________________________

Time of Administration: ___________________________ If PRN, frequency: ___________________________

Relevant side effects: □ None expected □ Specify: ___________________________

ALLERGIES: □ NO □ YES (specify): ___________________________

Medication shall be administered from: ___________________________ to ___________________________

Valid for maximum of 1 year Month / Day / Year

Prescriber’s Name/Title: ___________________________

(Type or print)

Telephone: ___________________________ Fax: ___________________________

Address: _____________________________________________

Prescriber’s Signature: ___________________________ Date: ___________________________

Use for Prescriber’s Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. 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. I give permission for the exchange of information between the prescriber and the school nurse when necessary to ensure the safe administration of such medication.

Parent/Guardian Signature: ___________________________ Date: ___________________________

Parent’s 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: Competency evaluation required.

☑ Yes □ No ___________________________ Signature Date

Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2

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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, 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: ___________________________ Date of Birth: ___________________________

Address: ________________________________________________________________

Condition for which drug is being administered: _______________________________

Drug Name: ___________________________ Dose: ___________________________ Route: __________

Time of Administration: ___________ If PRN, frequency: _______________________________________________________________________

Relevant side effects: □ None expected □ Specify: ______________________________________

ALLERGIES: □ NO □ YES (specify): ____________________________________________________________________________________

Medication shall be administered from: ___________________________ to ________________

Valid for maximum of 1 year

Month / Day / Year to Month / Day / Year

Prescriber’s Name/Title: ___________________________ (Type or print)

Telephone: ___________________________ Fax: ___________________________

Address: _____________________________

Prescriber’s Signature: ___________________________ Date: ___________ Use for Prescriber’s Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. 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. I give permission for the exchange of information between the prescriber and the school nurse when necessary to ensure the safe administration of such medication.

Parent/Guardian Signature: ___________________________ Date: ___________

Parent’s Home Phone #: ___________________________ Work #: ___________________________

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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: ___________________________ Signature Date

Competency evaluation required. Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

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Prescriber's Authorization

Name of Student: ___________________________ Date of Birth: ____________

Address: ____________________________________________________________________________

Condition for which drug is being administered: ____________________________________________

Drug Name: ___________________________ Dose ___________ Route: ___________

Generic and trade name: ___________________________ Time of Administration: ____________

Relevant side effects: □ None expected □ Specify: ___________________________

ALLERGIES: □ NO □ YES (specify): ____________________________________________________________________________

Medication shall be administered from: ___________________________ to ___________________________

Valid for maximum of 1 year

Month / Day / Year to Month / Day / Year

Prescriber's Name/Title: ___________________________ (Type or print)

Telephone: __________________ Fax: ___________

Address: ____________________________________________________________________________

Prescriber's Signature: ______________________ Date: __________________ Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. 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. I give permission for the exchange of information between the prescriber and the school nurse when necessary to ensure the safe administration of such medication.

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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: Competency evaluation required.

Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2

Signature ____________ Date ____________

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