PRESTON PUBLIC SCHOOLS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Connecticut State Law and Regulations require a physician's, dentist's, advanced practice registered nurse or physician's assistant's written order and parent/guardian's authorization for a nurse to administer medications or in her absence the principal, teacher, licensed physical or occupational therapist of a school or a coach to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, authorized prescriber's name and date of original prescription. Non-prescription medications must be in original properly labeled containers.

AUTHORIZED PRESCRIBER'S ORDER

Name of Child _____ Date of birth _____
Address_____
Condition for which medication is ordered_____
Medication: Name, dose, method and time of administration _____
_____
_____
Medication administered from _____ to _____

Date Date

Relevant side effects to be observed _____
Plan for management of side effects _____
Is this a controlled drug? _____ If yes, DEA number _____

SELF ADMINISTRATION OF INHALER AND/OR EPIPEN

1. I have conferred with student's parent/guardian and authorize self administration of this inhaler or epipen.
YES [ ] NO [ ]
2. I have appropriately instructed this student regarding self administration. YES [ ] NO [ ]

Prescriber's Name _____ Signature_____
Date _____ Telephone Number _____

AUTHORIZATION BY PARENT/GUARDIAN FOR ADMINISTRATION OF MEDICATION

I hereby request that the above medication order for my child, _____, by his/her health care provider be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container, properly labeled and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if not picked up within one week following the termination of this order.
I do [ ] do not [ ] want my child to receive this medication on early dismissal days (1:00 p.m.)
Name _____ Signature _____

Relationship to child _____ Date _____ Telephone _____
Address _____