School District:_____**School**_____ **Grade:**_____

PRESCRIBER'S AUTHORIZATION FOR THE ADMINSTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-9 require a written order from an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician's assistant, optometrist and for athletic events only, a podiatrist) and parent/guardian's written authorization, for school nurses, or in the absence of a nurse, other designated personnel to administer medications, including over–the-counter drugs.

Medications must be in the original, properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container. All medications must be delivered to school by a responsible adult. Medications can only be administered to the student that they are prescribed for.

Name of Student:_____**Date of Birth**:_____
Address:_____

Indication(s) for medication: _____ **Is this a controlled drug?** ☐ **NO** ☐ **YES**

DRUG *Name:*_____ Generic *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** _____
(up to 12 months from July 1 to June 30) **Month / Day / Year** **Month / Day / Year**

Prescriber's Name/Title: _____
(type or print)
Telephone: _____ _____**Fax:**_____

Address: _____

Prescriber's Signature: _____**Date**_____

Nurse/or Designated Personnel Signature:_____**Date**_____

Use for Prescriber's Stamp

PARENT / GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 3 months supply of medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature:_____**Relationship to student:**_____**Date:**_____

Parent's Home Phone #:_____ _____ **Work #:**_____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/ APPROVAL

For capable students with a chronic medical condition, self-administration of emergency non-controlled medications may be authorized by the prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212-4 and 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/review for self administration: ☐**NR*** ☐**YES** ☐ **NO** _____
Signature **Date**

Revised: 5/11 NR* means not required **Received by**_____**Date:**_____

SHELTON PUBLIC SCHOOLS **SCHOOL HEALTH SERVICES**

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires *a prescription or over-the-counter medication* during the school day or during intramural or interscholastic athletic events, you must follow the procedures required by the Shelton Public Schools, the Connecticut General Statues, Sec. 10-212a, and the Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-9. These procedures promote safe practices for students and staff. Please read them carefully.

1. An authorized prescriber's (physician, dentist, advanced practice registered nurse, physician assistant or optometrist, or for athletic events only, a podiatrist) written order must be obtained from the parent for each medication that must be administered daily or an as-needed basis.

2. A new order is required each year and if so prescribed, **may be effective from July 1st through June 30th** of the given year. A medical order dated July 1 of a year will cover summer programs and the upcoming school year.

3. <u>The authorized prescriber must fill in the information requested on the form for prescription and over-the-counter medications:</u>
    a. ***Name*** of medication, also the ***generic name*** of the medication, and strength of the medication;
    b. Indication(s) for the administration of this medication in school (condition, diagnosis);
    c. Amount (dosage) of the medication to be administered and route of administration;
    d. Potential side effects of the medication;
    e. Time of day that the medication is to be administered; and frequency for PRN (as-needed);
    f. Duration of the order for administration of the medication (up to 12 months from July through June 30th of the same school year);
    g. If applicable, authorization for self-administration in school of emergency medication (cartridge injectors or rescue asthma inhalers) for chronic medical conditions or medically-diagnosed allergies.

4. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form and, if applicable, provide authorization for self-administration in school.

5. 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 information.

6. The medication and completed authorization form **must be delivered to the school nurse by a responsible adult**, except that, once the nurse has reviewed the medial order and developed a plan for self-administration, the student is responsible to carry the medication to/from school each day and maintain its safe control at all times.

7. Self administration plans approved for the school day also extend to extra curricular activities and athletics.

8. Self administration of controlled medication is not permitted.

9. No more than a three (3) month supply may be stored at school. **Unused medication must be destroyed** if not picked up by a responsible adult by the end of the last day of school.

Parent or Guardian may come to school and administer the medication themselves.
Thanks you for your cooperation.
Please contact the school nurse if you have any questions.