Westbrook Public Schools

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, 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.*

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

PRESCRIBER'S AUTHORIZATION:

Condition for which drug is being administered: _____
Name of Drug: _____Dose: _____ Route: _____
Time of Administration: _____ If PRN, frequency: _____
Relevant side effects: None expected ☐ 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: _____

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 45 day 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: _____

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