Authorization for the Administration of Medication by Qualified School Personnel

The Connecticut State law requires a physician/dentist/optometrist/APRN/PA's written order and signature **and** a parent/guardian's signature for a school nurse or qualified school personnel to administer medication. Medication must be received in pharmacy-prepared containers, labeled with the student's name, name of drug, strength, dosage, frequency, prescribing provider's name and date of original prescription. Parent/guardian or responsible adult must deliver the medication, limited to a 45-day supply.

LICENSED PRESCRIBING PROVIDER'S ORDER:

Name of Student ____D.O.B.__________________

Condition for which drug is being administered____

Name of medication- generic and brand name____

Dosage of medication ____

Route of administration __________________Time of administration________________________

Dates of administration: from ___________________to____________________

Is this a controlled drug? _____________DEA number_______________________

Side effects____

Management plan____

SELF ADMINISTRATION:
***Is this student capable of self-administration?* _______Yes ______No**

____
Prescribing provider's signature

Date: ___________ Phone:________________ **Provider stamp**___________________________

SCHOOL AUTHORIZATION for student to self-administer:
***Is this student capable of self-administration?* _______Yes ______No**

_____________________________ School RN

AUTHORIZATION OF PARENT/ GUARDIAN:
I request that my child, ______________________, be assisted/ supervised (to include self-administration medications as needed) in taking the above medication at school. I will comply with the policies and procedures determined by the school district. I consent to communication between school nurse and prescriber regarding any issues with this medication.

____Date:__________________
Signature of parent/guardian

Home Phone___________________________ Emergency Phone_____________________________