

**TRUMBULL SCHOOL HEALTH PROGRAM
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL**

Name of Student _____ **DOB** _____ **Grade** _____

Known Allergies _____

Connecticut State Law requires:

1. The written order of an MD, OD, DDS, APRN, or a PA for **prescription and non-prescription medications**.
2. Written authorization from the parent/guardian for medications, prescription and non-prescription, to be administered by school personnel.
3. Medication must be received and stored in the **original container**.
4. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent/guardian or other responsible adult.
5. No more than a 45 day supply of medication may be left at school.
6. Inhalant medications may be self-administered at all grade levels with the approval of the school nurse.
7. Self-administration must be authorized by the MD or authorized prescriber and parent/guardian.

This portion to be completed by Parent or Legal Guardian

I hereby give my permission for my child to receive the medication ordered by a licensed prescriber, recognized by the State of Connecticut. Medication is to be administered by:

- School Nurse, teacher or principal, trained in the administration of the medication.
 Child may self-administer with approval of licensed prescriber and School Nurse.

Please check:

- request the medication be administered on shortened school days. Yes No
 request the medication be administered on field trips. Yes No

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school, whichever comes first.

Signature of Parent/Guardian _____ **Home Phone** _____

Date _____ **Work Phone** _____

This portion to be completed by Physician/Licensed Prescriber ONLY

Name of Medication _____ **Dosage** _____

Route of Administration _____ **Frequency** _____

Time to be given in School _____

Start Date _____ **Stop Date** _____

Reason for Medication _____

Side Effects and Plan for Management _____

Special Instructions _____

Is this medication a sample? Yes No

Is the student capable of self-administering? Yes No

Permission to give in school if failed to receive dose at home? Yes No

Physician or Authorized Prescriber _____

(PLEASE PRINT OR TYPE CLEARLY)

Address _____ **Phone** _____

_____ **FAX** _____

Date _____ **Signature** _____

PLEASE NOTE: SIGNATURE MUST BE IN INK - RUBBER STAMPED ORDERS WILL NOT BE ACCEPTED.