SJ FAX 203-378-7306

ADMINISTRATION OF MEDICATION

The Connecticut State Law requires a physician's written order and a parent/guardian's authorization for a school nurse or other school personnel to administer medicinal preparations to students (including over the counter medication) during school hours or on a school trip. Enclosed is the necessary form to be completed by your physician if needed.

TRUMBULL PUBLIC SCHOOLS

SCHOOL:_____ GRADE: _____ DATE: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law requires a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse, physician' assistant, optometrist and, for athletic events only, a podiatrist) and parent/guardian written authorization, for school nurses, or in the absence of a nurse, othe designated personnel to administer medication, including over-the-counter drugs. Medications must be in the original, properly labeled container and dispensed b a physician/pharmacist. Over-the-counter medications must be delivered in an unopened labeled container. ALL medications must be delivered to school by responsible adult.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____

Address:_____

Indication(s) for medication:_____

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: _____ _____

Telephone:_____ Fax: _____

Address:_____

_____

Prescriber's 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 th prescriber that are necessary to ensure safe administration of this medications. I understand that I must provide the school with no more than a 3 month supply c medication. I understand that this medication will be destroyed if not picked up within one week following termination the order or the last day of schoo whichever comes first.

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Phone #:_____ Work #:_____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a chronic medical condition, self-administration of emergency and some other non-controlled medications may be authorized by th prescriber and parent/guardian. School nurse approval may be required according to CT State Regulations, Section 10-212a-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 for self administration: ___NR* ____yes ____no _____
Signature Date

Received by_____ Date of Receipt:_____