

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The **Connecticut State Law & Regulations** *REQUIRE* a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications, or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and the date of original prescription. This includes medication such as (but is not limited to) Tylenol, asthma inhalers, eye or ear drops, cough medicines, daily prescribed prescriptions, etc.)

PHYSICIAN's or DENTIST's ORDER

Name of Child: _____ Date: _____

Address: _____ Date of Birth: _____

Condition for which drug is being administered during school hours: _____

Drug: (name, dose & method of administration) _____

Time of administration: _____

Medication shall be administered from _____ to _____
(start date) (end date)

Relevant side effects to be observed, if any _____

If there are any side effects, plan for management: _____

Is this a controlled drug? YES NO If yes, DEA number _____

Physician/Dentist Name: _____ Phone # _____

Address: _____

Physician/Dentist Signature: _____ Date _____

Nurse/Principal/Teacher: _____ Date _____

AUTHORIZATION BY PARENT/GUARDIAN

for the administration of the above medication by school personnel:

Date: _____

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for my child, _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and supply of said medication. I further understand that his medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

NAME: _____ Signature: _____

Address: _____

Relationship to child: _____ Phone # _____