DANBURY PUBLIC SCHOOLS

School: _____ Grade: _____ **School Year _____**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a through 10-212a9 require a written medication order from an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization for the nurse, or in the absence of the nurse, other qualified designated personnel to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over-the-counter medications must be delivered in an unopened, properly labeled container. ALL medications must be delivered to school by an 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: (up to 12 months) _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
Type or Print

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 I consent to communications between the prescriber and the school nurse that are necessary to ensure the safe administration of this medication. I understand that I must provide the school with no more than a three (3) month 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: _____

Parent's Home Phone #: _____ Cell # _____ 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 the 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

*NR: Not Required

Health Services: 7/12