West Haven Public Schools

School: ____ Grade: _______

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law and Regulations require an authorized prescriber's (physician, dentist, optometrist, advanced practice registered nurse, or physician's assistant and for interscholastic and intramural athletic events only, a podiatrist) written order and parent or guardian's authorization for a nurse to administer medications or, in the absence of the nurse, qualified school personnel to administer medications. Medications must be in the original properly labeled container and dispensed by a physician or pharmacist.

PRESCRIBER'S AUTHORIZATION

Name of Student ____Date of Birth: ____________________

Condition for which drug is being administered: ____

Drug/generic name: ________________________________ Dose: ____________________ Route: _________________________

Time of administration: _____________________________________ Frequency, if PRN: ________________________________

Relevant side effects: [ ] None expected [ ] Yes (Specify): ____

ALLERGIES: [ ] NO [ ] YES (Specify): ____

Medication shall be administered from (date) ________________________________to (date) ______________________________

Medication needed for Field Trip: _______yes______no Medication to be given on half day: ______yes ______no

Prescriber's Name/Title: ____ Phone #: _____________ Fax #: ____________

Address: ____

Signature: ____ Date: ______________________________

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 3 month supply of medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school, whichever comes first. I grant permission for the school nurse to exchange information with this prescriber regarding the administration of this medication.

Parent/Guardian's Signature: ____ Date: __________________________________

Telephone (home) ______________________________(work) ______________________________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of a medication **may** be authorized by the prescriber and parent/guardian for **certain** medications. Authorization **must** be presented to the school nurse in accordance with Board policy and district nursing protocols.

Prescriber's authorization for self-administration: [ ] Yes [ ] No _________________________________ Date: __________
(signature)

Parent/Guardian authorization for self administration:[ ] Yes [ ] No _________________________________ Date: ___________
(signature)

School nurse approve for self administration [ ] Yes [ ] No _________________________________Date: ___________
(not required for inhalers or cartridge injectors)
(signature)

Med. #49
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