STRATFORD PUBLIC SCHOOLS
Stratford, CT

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) and Board of Education policy requires the following:

1. **A written medication order** form a licensed Medical Doctor (MD), Osteopathic Doctor (OD), Dentist (DDM or DDS), Advanced Practice Registered Nurse (APRN), or Physician Assistant for prescription and "over-the-counter" (nonprescription) medication which needs to be given in school.
2. **Written parental/guardian consent** for medication administration in school.
3. **Delivery** of Medication to the school nurse by a **responsible adult**, preferably the parent/guardian.
4. **Medication in the original container with proper labeling** (name of medication, student's name, dosage and frequency of administration, time or conditions of use).
5. **Approval by the school nurse**, in addition to the written authorization, for self-administration of medications in school.

MEDICAL AUTHORIZATION

NAME OF STUDENT _____ D.O.B. _____ DATE _____

MEDICATION NAME _____ DOSAGE _____

CONDITION REQUIRING MEDICATION _____ ALLERGIES _____

SIDE EFFECTS TO BE NOTED AND MANAGEMENT PLAN _____

MEDICATION TO BE ADMINISTERED FROM (DATE) _____ TO (DATE) _____

Permission to give in school if dose missed at home. (Please circle one) Yes No
Student may *self-administer* medication *with supervision* (Please circle one) Yes No
Student may self-administer medication without supervision after school nurse has confirmed that student knows indications for medication and proper administration techniques. (Please circle one) Yes No

PRESCRIBER'S NAME/TITLE _____ PHONE _____

ADDRESS OF PRESCRIBER _____

PRESCRIBER'S SIGNATURE _____ DATE _____

PARENT /GUARDIAN AUTHORIZATION

1. I request that the above ordered medication be administered by school personnel.
2. I understand that I may bring only a 45 day supply of medication to school and it is my responsibility to pick up the medication at the end of the school year or within one week following the termination of the medical order.
3. I **would** or **would not** like this medication to be administed on a field trips or early dismissal days. (Please circle one)

PARENT/GUARDIAN NAME (print) _____ PHONE # _____

PARENT/GUARDIAN SIGNATURE _____ ALT PHONE # _____