

**ELLINGTON PUBLIC SCHOOLS
STUDENT HEALTH SERVICES**

Authorization for the Administration of Medicines by School Personnel

The Connecticut State Law and regulations require a M.D.'s, O.D.'s, D.D.'s, A.P.R.N.'s or a P.A.'s written order and parent or guardian authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. All medications, prescription and nonprescription, must be in pharmacy prepared containers, and labeled with the name of the child, name of the drug, strength, dosage, frequency, physicians/dentist's name and date of original prescription.

PHYSICIAN'S OR DENTIST'S ORDER

NAME OF STUDENT _____

DATE _____

KNOWN ALLERGIES _____ DATE OF BIRTH ____/____/____

CONDITION FOR WHICH DRUG IS BEING ADMINISTERED _____

Drug _____

Name	Dose	Method of Administration	Time to be Given
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If student is to administer his/her own medication, please indicate that you feel the child is capable of self- administration () yes () no__

Medication shall be administered from _____

_____ to _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____ **If yes, DEA number** _____

Permission to give in school if failed to give dose at home() yes () no

PHYSICIAN'S / DENTIST NAME (print) _____ PHONE _____

ADDRESS _____

PHYSICIAN'S /DENTIST'S SIGNATURE

AUTHORIZATION OF PARENT / GUARDIAN for the administration of the above medication by school personnel.

Child's Name _____

Grade _____ Date _____

I hereby request that the above medication , ordered by the physician / dentist for my child _____ be given as checked in (a) or (b) below:

_____ (a) be administered by school personnel

_____ (b) be self administered by student.

Please note all self administered medications, except inhalers. must be kept in the nurse's office.

I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a pharmacist and will provide **no more than a 45 day supply** of said medication. I understand that this 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 (print): _____

Relationship to child _____

Address: _____

Phone _____

Signature _____ Date _____

DO you want the medication given on a field trip? ()yes () no

DO you want medication given on a half day? () yes () no

If your child takes a morning dose at home and a noon dose in school, please notify the school nurse if you give the morning dose at a later than usual time on a late opening day.