ELLINGTON PUBLIC SCHOOLS
STUDENT HEALTH SERVICES
Authorization for the Administration of Medicine by School Personnel

Connecticut State Law and Regulations require a written order from an authorized prescriber (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization for the school nurse, or in the absence of the school nurse, the school principal or teacher to administer medication. All prescription medication must be in the pharmacy prepared container with the proper pharmacy label attached. Non-prescription medication must be in original, unopened packaging.

PRESCRIBER AUTHORIZATION

Name Of Student _____ Date of Birth ____/____/____
Known Allergies _____
Condition For Which Drug Is Being Administered _____

Drug Name	Strength	Dose	Method of Administration	Time to be Given

Medication shall be administered from ____/____/____ to ____/____/____
month/day/year month/day/year

Relevant side effects: Specify _____ None Expected ☐
If there are side effects, plan for management _____
Is this a controlled drug? ☐ Yes ☐ No
If yes, DEA Number _____
Permission to give in school if failed to give dose at home ☐ Yes ☐ No

Prescriber's Stamp

Prescriber Name (print) _____ Phone _____
Address _____
Prescriber Signature _____ Date ____/____/____

PARENT/GUARDIAN AUTHORIZATION

DO you want the medication given on a field trip? ☐ Yes ☐ No
DO you want medication given on a half day? ☐ Yes ☐ No

I hereby request that school personnel administer the above ordered medication. I understand that I must supply the school with no more than a 45 school day 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 authorize the school nurse to discuss and collaborate with the authorized prescriber on the safe administration of said medication as well as the management of the health problem for which said medication is prescribed.

Parent/Guardian Name (print) _____ Relationship to Child _____
Address _____ Phone _____
Parent/Guardian Signature _____ Date ____/____/____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Ellington Board of Education 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 ☐ Yes ☐ No _____
Signature Date

Revised 5/5/16