LYME-OLD LYME PUBLIC SCHOOLS

Small Schools, Big Ideas ***Challenging * Achieving * Excelling***

REGION #18

Authorization for the Administration of Medication by School Personnel

Available for download at: www.region18.org/page.cfm?p=626

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber (physician, dentist, advanced registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly-labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of student: _____ Birth date (*mm/dd/yyyy*): ___/___/_____

Address: _____

Condition for which drug is being administered: _____

Drug name: _____ Dose: _____ Routine: _____

Time of administration: _____ If PRN, frequency: _____

Relevant side effects: ____ None expected ____ Specify: _____

Medication shall be administered from (*mm/dd/yyyy*): ___/___/_____ until (*mm/dd/yyyy*): ___/___/_____

Prescriber's name and title: _____

Telephone number: (____) ____-_____x_____ Fax number: (____) ____-_____x_____

Address: _____

Prescriber's signature: _____ Date (*mm/dd/yyyy*): ___/___/_____

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 45-day supply of medication. I understand that this medication will be destroyed if not picked up within one week following the termination of the order or the last day of school, whichever comes first.

Parent/guardian signature: _____ Date (*mm/dd/yyyy*): ___/___/_____

Home phone number: (_____) _____-_____ Work phone number: (____) ____-_____x_____

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 Regional School District #18 Board of Education policy. Only asthma inhalant medications and Epipens for Middle and High School students may be approved; only non-controlled medications for High School field trips may be approved for self-medication.

Prescriber authorization for self-administration: ___ Yes ___ No _____
Signature and date

Parent/guardian authorization for self-administration: ___ Yes ___ No _____
Signature and date

School nurse approval for self-administration: ___ Yes ___ No _____
Signature and date