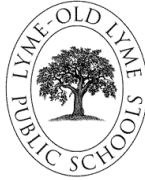


# LYME-OLD LYME PUBLIC SCHOOLS

*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](http://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*