LEDYARD PUBLIC SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice 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: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Allergies: ☐ NO ☐ YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____
_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

Parent/Guardian Authorization

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

☐ I wish ☐ I do not wish the medication to be administered on shortened school days.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work #: _____

Self-Administration of Medication Authorization/Approval (Epi-Pen and Inhalers only)

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

Prescriber's authorization to self carry and self administer: ☐ No ☐ Yes _____
Signature & Date

Parent/Guardian authorization to self carry and self administer: ☐ No ☐ Yes _____
Signature & Date

School nurse approval to self carry and self administer: ☐ No ☐ Yes _____
Signature & Date