AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law requires a written order from a physician, dentist, APRN, or physician assistant licensed to practice medicine in CT and the written authorization of a parent/guardian of such child for a school nurse, principal, teacher, or coach to administer medication to any student.

Physician’s Name: ______________________________  CT License #: _______________ Tel: _________________

Name/Address: ______________________________________________________________

Physician’s Order – Date of Order: ______________________________________________

Name of Child: ___________________________________ Date of Birth: ________________

Condition for which drug is being administered during school hours: ________________________________

Name of Drug: _______________________________ Is this a controlled drug? _________________

Dose of drug to be administered __________________________________________________________

Time(s) drug is to be administered ___________________________ Method of administration __________________

Please indicate that you feel the child is capable of self administration yes ☐  no ☐

Medication shall be administered from School Year (2023) to School Year (2024) ____________________________

Relevant side effects, plan for management _______________________________________________________

Signature of Physician/APRN/PA/Dentist: __________________________________________________________

Signature of Nurse/Principal/Teacher: __________________________________________________________

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AUTHORIZATION OF A PARENT OR GUARDIAN CONCERNING THE ADMINISTRATION OF ABOVE MEDICATION BY SCHOOL PERSONNEL

To: __________________________________________________________ Date: ________________

Name of School

I hereby request that the above medication ordered by the physician for my child be given as checked below: Name of Child __________________________

(a) ______ be administered by school personnel

(b) ______ self-administered

I understand that I(parent/guardian) must supply the school with the medication in the original pharmacy prepared container, properly labeled, and will provide no more than the supply of said medication requested by the school. I understand this medication will be destroyed if it is not picked up within one week following termination of the request or one week beyond the close of the school year.

SIGNATURE OF PARENT OR GUARDIAN: __________________________________________________________

ADDRESS _______________________________________________________________________________________

TELEPHONE _____________________________________________________________________________________

Revised: 5/2023 Nurse Cheryl