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: ____

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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 GURARDIAN: ____

ADDRESS ____

TELEPHONE ____

Revised: 5/2023 Nurse Cheryl