

School District ACES School \_\_\_\_\_ Grade \_\_\_\_\_

**SCHOOL MEDICATION AUTHORIZATION**

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication. Medications must be in the original properly labeled container. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 2015 -2016 School Year is defined as July 1<sup>st</sup> to June 30<sup>th</sup>

Self administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and parent/guardian. All other medications considered for self-administration must be approved by the school nurse in accordance with Board policy to confirm student safety and competency with medication procedure.

**Prescriber's Authorization**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which medication is indicated: \_\_\_\_\_ Medication  NKDA  
Allergies  Yes: \_\_\_\_\_  
Generic Medication: \_\_\_\_\_ mg puffs amp other  
Dose: \_\_\_\_\_ Route: PO GT / NGT  
Inhaled with Spacer

Time of Administration \_\_\_\_\_ AM PM Side Effects: \_\_\_\_\_  
Not relevant

If PRN, frequency, Q \_\_\_\_\_ Hours Provider Name & Phone/Fax Numbers

<p><b>Prescriber's Authorization for Self-Administration</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Confirms that the student has been instructed to safely and properly administer this medication)</i></p>	<p><b>(printed or stamped)</b></p>
Prescriber's Signature _____ Date: _____ Printed: _____	

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

I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe administration of this medication and the safe management of the condition for which it is prescribed.

**Parent/Guardian Authorization for Self-Administration**  Yes  No

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone# \_\_\_\_\_ Work/ Cell # \_\_\_\_\_

**School nurse approval for Self Administration**  NR\*  Yes  No

\*NR mean Not required for inhalers or cartridge injectors

Signature \_\_\_\_\_ Date \_\_\_\_\_