School District: Norwalk, CT School: Norwalk High School Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE 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 the drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, Frequency: _____

Relevant Side Effects ☐ None ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (Specify): _____

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

Prescribers Name / Title: _____ (Type or Print)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____

Use for Prescriber's Stamp

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 following termination of the order or the last day of school, whichever comes first.**

Parent / Guardian Signature: _____ Date: _____

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

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 Board policy.

Prescriber's authorization for self-administration: ☐ Yes ☐ No _____ (Signature) _____ (Date)

Parent/ guardian authorization for self-administration: ☐ Yes ☐ No _____ (Signature) _____ (Date)

School Nurse authorization for self-administration: ☐ Yes ☐ No _____ (Signature) _____ (Date)