PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a prescription or over-the-counter medication during the school day, these are the guidelines required by Connecticut General Statutes, Sec. 10-21a and Connecticut Administrative Regulations, Sec 10-21a-1 through 10-21a-10. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, ophthalmologist or physician assistant) using the Authorization for Administration of Medicine by School Personnel (see other side). A new order is required each year.

2. The authorized prescriber must fill in the information requested on the form:
   a. Student Name
   b. Name and generic name of medicine
   c. Dosage of medication
   d. Route, time, frequency of administration
   e. Indication for medication
   f. Any potential side effects including overdose or missed dose of medication
   g. Start and termination dates not to exceed 12 month period
   h. Written signature of prescriber

3. A parent or guardian must sign the “Parent/Guardian Authorization” portion of the form.

4. The medication must be packaged in the ORIGINAL PHARMACY CONTAINER, Clearly labeled with the student’s name, the authorized prescriber’s name, and the prescription.

5. The medication and completed authorization form must be DELIVERED TO THE SCHOOL NURSE BY A RESPONSIBLE ADULT.

6. No more than a 3 month supply may be stored at the school.

7. At the end of the school year, medication not picked up by parent or guardian will be destroyed per Sec 10-212a-5-l4l.

8. Thank you for your cooperation. Please contact the school nurse at your school if you have any questions.

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Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication’s administration, and date of the prescription.

Authorized Prescriber’s Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____________________________ Date of Birth / / Today’s Date / /
Address of Child/Student _____________________________ Town _____________________________
Medication Name/Generic Name of Drug _____________________________ Controlled Drug? □ YES □ NO
Condition for which drug is being administered: _____________________________
Specific Instructions for Medication Administration _____________________________
Dosage _____________________________ Method/Route _____________________________
Time of Administration _____________________________ If PRN, frequency _____________________________
Medication shall be administered: Start Date: / / End Date: / /
Relevant Side Effects of Medication ____________________________________________ □ None Expected
Explain any allergies, reaction to/negative interaction with food or drugs _____________________________
Plan of Management for Side Effects ____________________________________________
Prescriber’s Name/Title _____________________________ Phone Number (__) _____________________________
Prescriber’s Address _____________________________ Town _____________________________
Prescriber’s Signature _____________________________ Date / /
School Nurse Signature (if applicable) _____________________________

Parent/Guardian Authorization:
□ I request that medication be administered to my child/student as described and directed above
□ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
□ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____________________________ Relationship _____________________________ Date / /
Parent/Guardian’s Address _____________________________ Town _____________________________ State __________
Home Phone # (__) Work Phone # (__) Cell Phone # (__) _____________________________

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 (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.

Prescriber’s authorization for self-administration: □ YES □ NO _____________________________ Signature _____________________________ Date

Parent/Guardian authorization for self-administration: □ YES □ NO _____________________________ Signature _____________________________ Date

School nurse, if applicable, approval for self-administration: □ YES □ NO _____________________________ Signature _____________________________ Date

Today’s Date _____________________________ Printed Name of Individual Receiving Written Authorization and Medication _____________________________
Title/Position _____________________________ Signature (in ink) _____________________________

Note: This form is a sample form in compliance with Section 19-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)