NEWTOWN PUBLIC SCHOOLS

Authorization for the Administration of Medication by School Personnel

In Connecticut schools administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes (10-212a) and Regulations. Parents/guardians requesting medication administration to their child by the school nurse, or in the absence of the nurse, other qualified designated personnel shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for administration, and date of the prescription.

Authorized Prescriber's Order

(Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist)

Name of Student:_____Date of Birth____/____/____ Today's Date_____/_____/_____

Address_____

Drug name:_____Controlled Drug? YES____NO_____

Condition for which drug is being administered_____

Dosage:_____Time of Adminstration_____

Start Date_____/_____/_____End Date _____/_____/_____

Permission to give in school if failed to receive dose at home: YES_____ NO_____

Relevant Side Effects of Medication _____ None Expected

Plan of Management for side effects _____

Prescriber's Name/Title _____ Phone (_____) _____

Prescriber's Address _____

PRESCRIBER'S SIGNATURE _____ Date _____/_____/_____

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I consent to communication between the prescriber and the school nurse that is necessary to ensure the safe administration of this medication. I understand that I must provide the school with no more than a three month supply of medication. I understand that this medication will be destroyed if not picked up by a parent/guardian within one week following termination of the order or the last day of school.

Parent/Guardian Signature_____ Date _____/_____/_____

Parent /Guardian'sAddress_____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

For capable students with a chronic medical condition, self-administration of emergency medication may be authorized by the prescriber and parent/guardian in accordance with state statute and Board of Ed policy.

PRESCRIBER'S AUTHORIZATION FOR SELF-ADMINISTRATION _____
Signature Date

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION: _____
Signature Date