City of Waterbury – Departments of Health and Education

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

FROM: MM/YYYY ______________ TO MM/YYYY ______________

ALL AUTHORIZATIONS NEED TO BE RENEWED IN AUGUST

SCHOOL DISTRICT - WATERBURY SCHOOL: GRADE:

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.

PRESCRIBER'S AUTHORIZATION

STUDENT NAME	DATE OF BIRTH

MEDICATION ALLERGIES

CONDITION FOR WHICH MEDICATION IS INDICATED	☐ NKDA ☐ YES

MEDICATION & GENERIC NAME	DOSE: ______ ☐ MG ☐ PUFFS ☐ AMP ☐ OTHER
	ROUTE: ☐ PO ☐ GT/NGT ☐ SC ☐ IM ☐ INHALED ☐ W/SPACER ☐ PER RECTUM

TIME OF ADMINISTRATION: ______ ☐ AM ☐ PM IF PRN : FREQUENCY Q ______ HOURS: ______

SIDE EFFECTS: ______________________

☐ NOT RELEVANT

PRESCRIBER'S AUTHORIZATION FOR SELF-ADMINISTRATION ☐ YES ☐ NO CONFIRMS THAT THE STUDENT HAS BEEN INSTRUCTED TO SAFELY AND PROPERLY ADMINISTER THIS MEDICATION DATE: PRESCRIBER'S SIGNATURE:	PRESCRIBER'S NAME, PHONE & FAX (PRINTED OR STAMPED) DATE: PRESCRIBER'S SIGNATURE:

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 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 NURSE AS NEEDED FOR THE SAFE ADMINISTRATION OF THIS MEDICATION.

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION: ☐ YES ☐ NO

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: ______________

PARENT'S HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

SCHOOL NURSE SELF ADMINISTRATION ASSESSMENT COMPLETED: ☐ YES ☐ NO DATE:	
APPROVAL FOR SELF ADMINISTRATION: *	☐ YES ☐ NO * *NOT REQUIRED FOR INHALERS OR CARTRIDGE INJECTORS*

SCHOOL MEDICAL ADVISOR'S SIGNATURE: ______________________ DATE: ______________