CROMWELL PUBLIC SCHOOLS

CMS/CHS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law requires a written order of an authorized prescriber (i.e., physician, dentist, advanced practice RN, or physician's assistant) and the written authorization of a parent or guardian for a school nurse to administer medication. **Medications are to be brought into the school by parent/guardian or other responsible adult and should be picked up by same at the end of the school year.**

Student's Name: _____ DOB: _____

Authorized Prescriber's Name: _____ Phone#: _____

Authorized Prescriber's Address: _____

Name of Medicine (including generic name): _____ Dose: _____

Route of Administration: _____ Time of Administration: _____

Condition for which drug is being administered during school hours: _____

_____

Is this a controlled drug? ☐ yes ☐ no

Medication shall be administered from: _____ (date) to: _____ (date)

Middle School and High School Only:

Asthma Inhaler Epinephrine Insulin Glucose tablets/gel ☐ may self-carry ☐ may self-administer

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Signature: _____ M.D. DEA #: _____

AUTHORIZATION OF A PARENT OR GUARDIAN CONCERNING THE ADMINISTRATION OF ABOVE MEDICATION BY SCHOOL PERSONNEL

I hereby request that the above medication ordered by an authorized prescriber for my child

_____
(Please print full name of student.)

_____ be administered by school personnel

_____ be administered on field trips

_____ be self-administered

_____ be administered on early dismissal days

I give permission for the exchange of information between the Prescriber and the School Nurse necessary to ensure the safe administration of such medication.

I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 3-month supply of said medication.

I hereby give permission to destroy the medication (or I understand that this medication will be destroyed) if not picked up by the last day of school.

_____ (signature) _____ (phone) _____ (date)

Self- Administration:

1. I have conferred with the child's parents/guardians and feel this medication may be self-administered.
2. This student has been appropriately instructed regarding self-medication.

Physician's/Dentist's/APRN's/PA's Signature: _____ Date: _____

Address: _____ Telephone #: _____