CROMWELL PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's/dentist's name, and date of original prescription.

PHYSICIAN'S OR DENTIST'S ORDER

Name of Student: ______________________________ Date: ______________

Address: ______________________________ DOB: ______________

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

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DRUG: Name (including generic name), dose and method of administration: ______________________________

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Time of Administration: ______________

Medication shall be administered from ______________ (date) to ______________ (date)

Relevant side effects to be observed, if any: ______________________________

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If there are side effects, plan for management: ______________________________

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Is this a controlled drug? ☐ yes ☐ no If yes, DEA number: ______________

Physician's or Dentist's Name: ______________ (Type or Print) Telephone #: ______________

Address: ______________________________

Physician/Dentist Signature: ______________________________ Date: ______________

Nurse/Principal/Teacher: ______________________________ Date: ______________

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

I herby request that the above medication, ordered by the physician/dentist of my child, ______________________________, be administered by school personnel. 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 give permission for the exchange of information between the prescriber and the School Nurse necessary to ensure the safe administration of such medication.

NAME: ______________________________ Date: ______________

SIGNATURE: ______________________________ Relationship to Child: ______________

Address: ______________________________ Telephone #: ______________

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