CITY OF MERIDEN – SCHOOL HEALTH PROGRAM

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a written order from a licensed Advance Practice Registered Nurse, Physician Assistant, Physician or Dentist and parent or guardian's authorization for a nurse to administer all medications or in her absence, the principal or teacher to administer medications. Medications must be in the original labeled container as dispensed from pharmacy or medical office. **All medications shall be delivered to the school by the parent, guardian or other responsible adult.**

Name of Student _____ D.O.B. _____

Address _____ Allergies _____

Condition for which drug is being administered during school hours _____

_____

DRUG: Name, dose and method of administration _____

_____

Time of administration _____ Medication shall be administered from _____ *date* to _____ *date*

Possible side effects and management _____

Is this a controlled drug? Yes _____ No _____ If yes, DEA number _____

If not a controlled drug, is this student capable of self-administering this drug? Yes _____ No _____

Is this medication to be administered on field trips and shortened school days? Yes _____ No _____

Health Care Provider Name _____ *Type or print* Telephone # _____

Address _____

Health Care Provider's Signature _____ Date _____

AUTHORIZATION OF PARENT OR GUARDIAN

SCHOOL _____ DATE _____

TO SCHOOL PERSONNEL:

I hereby request that the above medication ordered by the health care provider for my child be: *(please check)*

☐ self administered

☐ 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 health care provider or pharmacist and will provide no more than a 30 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Signature _____ Relationship to Child _____

Address _____ Phone _____

√ Student has successfully demonstrated the ability to self-administer.

School Nurse Signature _____ Date _____

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