THOMPSON PUBLIC SCHOOL
HEALTH SERVICES

SCHOOL YEAR_____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES

The Connecticut State law and regulations require a physician, APRN, or dentist's written order and parent/guardian's authorization for a nurse to administer medications or in her absence, the principal, teacher, or coach to administer medications. Medications must be in pharmacy prepared containers and labeled with the name and date of the original prescription and delivered to the school nurse by a responsible adult.

PHYSICIAN, APRN, DENTIST'S ORDER Date: _____
Name of Child: _____ Grade_____
Condition for which the drug is being administered during school hours: _____
_____
Drug Brand Name:_____**Generic Name**:_____
Dosage:_____ Time of Adm: _____Route of Adm:_____
Medication shall be administered from _____ to _____
(Date) (Date)
Relevant side effects to be observed, in any: _____
_____
If there are side effects, plan for management: _____
_____
Is this a controlled drug? _____ If yes, DEA number: _____
STUDENT MAY SELF ADMINISTER EMERGENCY MEDICATION: Yes____ No____
Physician, APRN, Dentist's Name: _____ Date: _____
(Print or Type)
Address: _____
PHYSICIAN, APRN, DENTIST'S SIGNATURE:
_____
Nurse/ Principal/ Teacher: _____ Date: ____
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AUTHORIZATION BY PARENT/ GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL

*Has the child's asthma/ allergy condition changed from the previous year? Yes ____ No ____
If yes, explanation: _____
I hereby request that the above medication, ordered by the prescriber, for my child;_____, be administered/overseen by school personnel. I grant permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of medication. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled as prepared by the pharmacy, and will provide not more than a 3 month school day supply of the 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.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____
Address: _____ Daytime Tel. #: _____