# Connecticut Technical High School System

**School:** _____ **Grade** _____ **Shop:** _____ **Date Received:** _____

## AUTHORIZATION FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Ct State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber (physician, dentist, advanced practice registered nurse, or physician's assistant) and written permission from the parent/guardian for the nurse, or in the absence of the nurse, a trained staff member to administer medication. **All non-prescription medications must be in their original, unopened container labeled with the student's name. All prescription medications must be in the original pharmacy labeled container. An adult must bring controlled medications (Ritalin, Concerta, etc.) to the school.**

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## PRESCRIBER'S AUTHORIZATION

Name of Student_____ Date of Birth_____

Address_____City_____State_____ Zip_____

Condition for which medication is being administered_____.

Name of Medication: _____ Dose: _____ Route_____

Schedule for Administration: _____. ☐ PRN for: _____.

Side Effects: ☐ None expected ☐Specify_____. Administer from: _____to _____.
**Month/Day/Year** **Month/Day/Year**

Allergies: ☐None ☐Yes (specify): _____

**Order for field trips**: ☐Give medication ☐ Omit medication. **Order for Production:** ☐Give medication ☐Omit medication. **Student has prescriber's permission to carry and self-administer:** ☐Epi-Pen ☐Inhaler ☐Diabetic Medications

**Prescriber's Signature**_____**Date**:_____

Name/Title_____

Address_____

Phone_____ Fax_____

**Prescriber's Stamp**

☐ ***A verbal order for the above medication was taken on*** _____

***from***_____ ***by***_____ ***RN, School Nurse***

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## PARENT/GUARDIAN AUTHORIZATION

I authorize the School Nurse or other medication administration trained school personnel to administer the medication ordered above. I understand that I must supply the school with no more than a 45 day supply of the medication and that the medication will be destroyed if not picked up within one week of being discontinued, or the last day of school, whichever comes first. I authorize the School Nurse to communicate with the prescriber regarding treatment for the condition noted above.

☐**I give permission for my child to carry and self-administer the above, if authorized by prescriber and School Nurse.**

**Parent/Guardian's Signature:** _____ Date**:** _____

**Phone Numbers**: _____ **(home#)** _____ **(work#)** _____ **(cell #)**

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☐Medication order was reviewed by School Nurse.
☐ Self-administration was reviewed, evaluated and approved by the School Nurse in accordance with CTHSS policy.

**School Nurse's Signature:** _____, RN **Date**: _____

MB 1/08