

# Connecticut Technical High School System

School: Vinal Technical HS 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.**

### 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 \_\_\_\_\_

A verbal order for the above medication was taken on \_\_\_\_\_

Prescriber's Stamp
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from \_\_\_\_\_ by \_\_\_\_\_ RN, School Nurse

### 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 #)

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: \_\_\_\_\_