

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL**

The Connecticut State Law and Regulations require a physician 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 designated to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, time of administration, physician's or dentist's name and date of original prescription.

**Physician or Dentist's Order:**

Name of Child: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Condition for which drug is being administered during school hours: \_\_\_\_\_

\_\_\_\_\_

Drug: Name, dose, and method of administration: \_\_\_\_\_

\_\_\_\_\_

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Time of administration: \_\_\_\_\_ Medication shall be administered \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)

Relevant side effects to be observed: \_\_\_\_\_

If there are any side effects, plan for management: \_\_\_\_\_

\_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_ If yes, DEA number: \_\_\_\_\_

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PHYSICIAN'S / DENTIST'S NAME: \_\_\_\_\_ Tel: \_\_\_\_\_  
(type or print)

Address: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR SELF-ADMINISTRATION:** Students will be allowed to self-administer inhalers or epi-pens only when the health problem could be life threatening, and there is a written order from a licensed physician for self-administration with written authorization of the parent or guardian of the child requesting self-administration. If a child is to self-administer his/her own inhaler/epi-pen, please indicate that you feel the child is capable of self-administration.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/Principal/Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION BY PAREN/GUARDIAN FOR ATHE ADMINISTRATION  
OF ABOVE MEDICATION BY SCHOOL PERSONNEL**

**To School Personnel:** I hereby request that the above medication, ordered by the physician/dentist for my child, \_\_\_\_\_, be administered by school personnel. I understand that I must supply the school with the prescribed, or the over the counter, medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up before the last day of school.

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Telephone: \_\_\_\_\_