BRISTOL-BURLINGTON HEALTH DISTRICT
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Public Health
Prevent. Promote. Protect.

Healthy People
Healthy Communities

School: _____ Date: _____

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse, or physician assistant and, for interscholastic and intramural athletic events only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, authorized personnel to administer medication. Prescription medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Non prescription medication (over the counter) must be in original, sealed, properly labeled container.

### Prescriber Authorization

**Name of Student: _____ Date of Birth _____**

**Address: _____**

**Condition for which drug is being administered: _____**

**Drug Name: _____ Dose: _____ Route: _____**

**Time of Administration: _____ If PRN, frequency: _____**

**Relevant side effects**: ☐ None Expected ☐ Specify: _____

**ALLERGIES:** ☐ NO ☐ YES (Specify): _____

Medication shall be administered from: _____ to _____
(Month/Day/Year) (Month/Day/Year)

Prescriber's Name/Title: _____
Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

**Use for Prescriber Stamp**

### PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 90 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or on the last day of school, whichever comes first. I give permission for the exchange of information between the authorized prescriber and school nurse to ensure the safe administration of such medication.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work#: _____ Alternate #:_____

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### SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

**Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy.**
**In school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian *only*; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.**

**1. Student to self-administer medication specified on this form: _____ YES _____NO**
**2. Student to possess medication specified on this form: _____ YES**

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

**Parent/Guardian Authorization and Signature: _____ Date: _____**

**School nurse Approval of self-administration (if applicable): _____ Date:_____**

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