



**BRISTOL-BURLINGTON HEALTH DISTRICT**  
 240 Stafford Avenue, Bristol, Connecticut 06010-4617  
 Tel. (860) 584-7682 • Fax (860) 584-3814 • [www.bbhd.org](http://www.bbhd.org)



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): \_\_\_\_\_

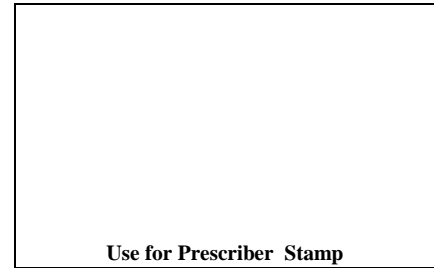
Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
 (Month/Day/Year) (Month/Day/Year)

Prescriber's Name/Title: \_\_\_\_\_

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

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

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**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 #: \_\_\_\_\_

**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: \_\_\_\_\_