BRISTOL-BURLINGTON HEALTH DISTRICT

240 Stafford Avenue, Bristol, Connecticut 06010-4617

Tel. (860) 584-7682 • Fax (860) 584-3814

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)

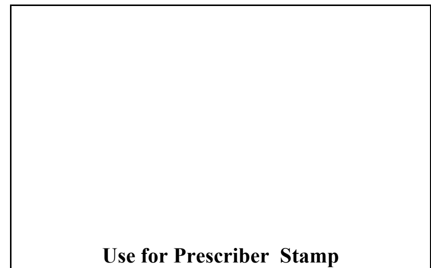
Prescriber's Name/Title: ______________________________

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 #:______________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy except in the case of an inhaler for asthma and/or cartridge injector medication for medically diagnosed allergy.

Prescriber authorization for self administration: ☐ YES ☐ NO ____________________

Parent/Guardian authorization for self administration: ☐ YES ☐ NO ____________________

School nurse approval for self administration: ☐ YES ☐ NO ____________________