

# RIDGEFIELD ACADEMY

## AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law 10-212a and Regulations 10-212a-1 through 10-212a-7 require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication, including over-the-counter drugs. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist. Over -the-counter medications must be delivered in an unopened, properly labeled container.

### PREScriBER'S AUTHORIZATION

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Condition for which drug is being administered \_\_\_\_\_

Drug Name/  
Strength \_\_\_\_\_ 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 \_\_\_\_\_  
Type or Print

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

Address \_\_\_\_\_

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

For  
Prescriber's Stamp

### PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. I understand that I must provide the school with no more than a 45 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 the last day of school, which ever comes first.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

I DO / DO NOT (circle one) wish the medication BROUGHT on field trips. \_\_\_\_\_

I DO / DO NOT wish medication ADMINISTERED on shortened days. \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of medication (inhalers and EpiPens) may be authorized for middle school students by the prescriber and parent/guardian and must be approved by the school nurse in accordance with CT Regulations, Section 10-212a-4, and Board policy.

Prescriber's authorization for self-administration	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
			Signature	Date
Parent/Guardian authorization for self-administration	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
			Signature	Date
School nurse approval for self-administration	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
			Signature	Date

Received by \_\_\_\_\_ Date of Receipt/Form \_\_\_\_\_ Date of Receipt/Medication \_\_\_\_\_