REGION 12 SCHOOL DISTRICT

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

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

Prescriber's Authorization

Name of Student	Date of Birth	Grade	
Address			
Condition for which drug is being administered			
Drug NameGeneric nan	ne	,Dose,Route_	
Time of Administration,	,If PRN, frequency_'		
Relevant side effects:O None expected D Spec	ify		
ALLERGIES: DNQ DYES Specify			
Medication shall be administered from (up to one ye	ear): Specify dates	to	
Prescriber's Name/Title Printed,			
TelephoneFax,			
Address,			
Prescriber's Signature	Date	Use for Provrder's Star	mp

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered to my child by school personnel. I consent to communication between the school nurse and the prescriber regarding any issues with the above named medication. I understand that I must supply the school with no more than three months supply of medication. I understand that a parent/guardian or a responsible adult must deliver the medication to the school nurse. I understand that the medication must be retrieved by a responsible adult when the order expires and/or the school year ends (within one week) or the medication wilf be discarded.

Telephone:Home # Work #Cell#	<u>-</u>

Authorization/Approval for Self Administration of Medication

A responsible student will be allowed to carry and self administer medication with the approval and authorization of the licensed prescriber, the parent/guardian, and the school nurse in accordance with Board Policy.

Prescriber's authorization for self administration (signature)	_Date
Parent/Guardian authorization for self administration (signoture)c	Dote
School Nurse approval for self administration (signature)	Date