South Windsor Public Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Connecticut state law and Board of Education Policy 5013 state that, "no medication, including non-prescription drugs, may be administered by any school personnel without the written medication order of an authorized prescriber; the written authorization of the student's parent or guardian or eligible student; and the written permission of a parent for the exchange of information between the prescriber and the school nurse necessary to ensure safe administration of such medication."

Student's Last Name, First Name	**Student's Date of Birth**

Student's School: ☐ ET ☐ OH ☐ PRS ☐ PV ☐ TEMS ☐ SWHS **Grade:**

**** ONE MEDICATION PER FORM. PHOTOCOPY AS NEEDED. PLEASE PRINT OR TYPE. ****

PHYSICIAN'S ORDER

DATE OF ORDER: _____

Physician's Name		Telephone/Address (Prescriber Stamp)
Physician's CT License Number		
Condition for which drug is being administered during school hours		Can child self-administer? ☐ Yes ☐ No
Brand Name of Drug and Strength	Generic Name of Drug	Is this a Controlled Substance? ☐ Yes ☐ No
Amount of drug to be administered for each dose	Time(s) drug is to be administered	Method of Administration
Period during which medication is to be administered ☐ School Year ☐ _____ to _____		Relevant side effects to be observed, if any/plan for management

PHYSICIAN'S/PRESCRIBER'S SIGNATURE **Date**

SPECIAL INSTRUCTIONS

1. Late arrival: ☐give AM on arrival ☐omit AM dose ☐delay doses 90 min ☐give doses on time ☐omit dose(s)

2. Early closing: ☐give as usual ☐omit dose(s) 3. **Field trips**: ☐give as usual ☐omit dose(s)

AUTHORIZATION OF PARENT/GUARDIAN FOR ADMINISTRATION OF ABOVE MEDICATION

I hereby request that the medication indicated above, as ordered by the authorized prescriber, be given to my child as follows:

☐ Administered by School Personnel ☐ Self-Administered per Board of Education policy

I understand that I must supply the school with the prescribed medication in the original container, dispensed and properly labeled by an authorized prescriber, and will provide no more than a 3-month supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school. I give permission for the exchange of information between the prescriber and the nurse to ensure the safe administration of medication.

Parent/Guardian Signature Date

Printed Name Daytime Phone Number

Please return this form to the nurse's office at your child's school. Fax numbers are provided below for your convenience:

Eli Terry:	860-644-4076	**Orchard Hill**:	860-644-2603	**Philip R. Smith**:	860-644-4027	**Pleasant Valley**:	860-282-2287
TEMS:	860-474-1580	**SWHS**:	860-474-1495	**District**:	860-291-1291		