

**TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM
AUTHORIZATION OF PARENT OR GUARDIAN FOR
ADMINISTRATION OF MEDICATION IN SCHOOL**

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student _____ Date of Birth _____

School _____ Grade _____

Medication _____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

Self-administration of medication means that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of this medication order in school.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

Date

Signature of Parent or Guardian

Telephone

Print Name of Parent or Guardian