TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a Physician or Dentist licensed to practice in the Untied States or an Advanced Practice Registered Nurse, Physician's Assistant, Optometrist or Podiatrist (for interscholastic & intramural events only) licensed to practice in Connecticut, and parent or guardian's written authorization for medication to be administered in school. All medications, prescription and non- prescription, shall be stored in their original container. All medications, except for those approved for transporting by students for self medication, shall be delivered to the school by a parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept in 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.

MEDICATION ORDER

Name of Student _____Date of Birth_____

Condition for which Drug is being Administered_____

BRAND name **AND GENERIC** name of drug (**PER STATE REGULATION)**

_____

Dosage: _____ Route: _____ Frequency:_____

Time to be given in school: _____

Administer Drug: from: _____ to _____
Date Date

Side Effects/Plan for Management: _____

Special Instructions:_____

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**

_____M.D./D.O./D.D.S./A.P.R.N./P.A./O.D./D.P.M.
Date Signature of Prescriber

_____
Print Name of Prescriber

_____
Address and Telephone

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

Student may self-administer the above medication (circle one) YES NO

For daily medications-Plan for early dismissal days (check one) _____Give medication as usual

_____ Do NOT give mediation in school

Plan for delayed opening :On days school opening is delayed , the parent /guardian must notify the School Nurse if any change in the student's medication schedule is needed

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

I authorize the medication be **destroyed** if it is not picked up within 1 week following termination of 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