

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, Optometrist or Podiatrist (for interscholastic and intramural events only), 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

For daily medication – Plan for early dismissal days (check one):

___ Give medication in school as usual

___ Do not give medication in school

- **Plan for delayed opening:**

On days that opening of school is delayed, the parent or 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 school nurse and prescriber of this medication as needed for implementation of that 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

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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