FAIRFIELD SCHOOL HEALTH PROGRAM
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Connecticut State Law requires a physician's or dentist's written and signed medication order and parent's or guardian's written authorization for all medications to be administered in school and on school trips. 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 Self- administration of medications by student is permitted at the high school level and, in special cases, at the middle school level. Inhalant medications may be self-administered at all grade levels. Self-administration must be authorized by the student's physician and parent and reviewed by the school nurse.

PHYSICIAN'S OR DENTIST'S ORDER

Name of Student:_____ Date of Birth:_____

School: _____**Tomlinson Middle School**_____ Grade:_____8_____

Condition for which drug is administered:_____

Medication is to be administered by: _____ Trained School Personnel OR
_____Student may self-administer

BRAND and GENERIC Name of Drug:_____

Dosage:_____ Route of Administration:_____

Frequency:_____ Time to be given:_____

Side Effects and Plan for Management:_____

Dates of Administration**:_____Philadelphia Trip October 16 -17, 2014**

Physician's Signature:_____ Date:_____

Address:_____ Phone Number:_____

AUTHORIZATION OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive the medication ordered by his/her physician or dentist. Medication is to be administered by:

_____Trained School Personnel OR _____Student may self-administer

I understand that this medication will be destroyed if not picked up by October 31, 2014.

_____ _____ _____

Date **Signature of Parent or Guardian** **Telephone**