

**BETHEL PUBLIC SCHOOLS
HEALTH SERVICES DEPARTMENT**

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations 10-212(a) require a written order from an authorized prescriber (physician, dentist, advanced practiced registered nurse or physician assistant) and a parent/guardian authorization for a nurse to administer medication. The principal or trained staff may administer medication. Medications must be in pharmacy prepared containers and appropriately labeled. This law also applies to over-the-counter medications.

MEDICATION ORDER

Name of Child: _____

Address: _____ Date of Birth: _____

Condition for which drug is being administered during school hours: _____

Drug Name: _____ Strength: _____ Dose: _____ Route: _____

Time(s) of administration: _____ If PRN, frequency _____

Relevant Side Effects: None Expected Specify: _____

ALLERGIES: NO YES, specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Student may self-administer: **Inhaler** YES NO **Epi-Pen** YES NO

Prescriber's Name/Title: _____

Prescriber's Signature: _____ Date: _____

Address: _____

Phone/Fax: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____

My child may self-administer: **Inhaler** YES NO **Epi-Pen** YES NO

Telephone (home) _____ (work) _____ (cell) _____

School Nurse authorization for student's self administration: _____
Inhaler YES NO **Epi-Pen** YES NO School Nurse's Signature / Date