School District:	School:	Grade:
Connecticut State Law and Regulations 10-212(a) requoted processes and parent/st, advanced practice registered nurse or pland parent/guardian written authorization, for the number of t	ADMINISTRATION OF MEDICINE BY SCHOO uire a written medication order of an authorized preschysician assistant and, for interscholastic and intramururse, or in the absence of the nurse, a designated princerly labeled container and dispensed by a physician/pherescriber's Authorization	riber, (physician, dentist, al athletic events only, a podiatrist) ipal or teacher to administer
Name of Student:	Date of Birth:	
Address:		·
	ered:	
Name and Generic name of Drug:	Dose:	Route:
Time 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)
Prescriber's Name/Title:		
Telephone:	(Type or print) Fax:	
Address:		
Prescriber's Signature:		
School Nurse Signature:	Date:	Use for Prescriber's Stamp
I hereby request that the above ordered medication information between the prescriber and the school number supply the school with no more than a three (3) picked up within one week following termination of the	ENT/GUARDIAN AUTHORIZATION be administered by school personnel and I give permis urse necessary to ensure the safe administration of thi month supply of medication. I understand that this m he order or the last day of school, whichever comes fir	s medication. I understand that I edication will be destroyed if not st.
Parent's Home Phone #:	Cell # Work	: #
Self administration of medication may be authorized accordance with Board policy. In the case of inhalers administer medication with only the written authorize guardian or eligible student.	ON OF MEDICATION AUTHORIZATION/APP by the prescriber and parent/guardian and must be ap for asthma and cartridge injectors for medically-diagno ation of an authorized prescriber and written authorize	proved by the school nurse in osed allergies, students may selfation from a student's parent or
Prescriber's authorization for self administ	Signature	Date
Parent/Guardian authorization for self adm	Signature	Date
School nurse approval for self administration	on: Yes No Signature	Date