**5141.21**
**FORM #2**

# AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications or in her absence the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription.

## PHYSICIAN OR DENTIST'S ORDER

Name of Child _____ Date _____

Date of Birth _____
Condition for which drug is being administered during school hours _____

_____

**DRUG:** name, dose and method of administration

Time of administration _____
Medication shall be administered from _____ to _____
*(Date)* *(Date)*
Relevant side effects to be observed, if any _____

_____
If there are side effects, plan for management _____

_____
Is this a controlled drug? _____ If yes, DEA number _____
Physician's/Dentist's Name _____ Tel. _____
(Type or print)
Address _____

Physician or Dentist's Signature _____ Date _____

Nurse/Principal/Teacher _____ Date _____

## AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

Date: _____

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for by child _____ be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name: _____
(Type or Print)

Signature: _____ Relationship to child: _____

Address: _____ Telephone: _____