

**AUTHORIZATION OF A PARENT OR GUARDIAN FOR MEDICATION TO BE GIVEN AT SCHOOL**

To: \_\_\_\_\_ School \_\_\_\_\_  
Name of Child \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Date \_\_\_\_\_

I hereby request the medication below as ordered by the authorized prescriber for my child,  
be given as checked in (a) or (b):

- (a) be administered by school personnel \_\_\_\_\_
- (b) be self-administered by the student in the presence of the nurse, principal or teacher \_\_\_\_\_

I hereby request the above medication, ordered by the authorized prescriber for my 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 an authorized prescriber and will provide no more than a 45  
school day supply of said medication. I understand 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. I give consent for  
communication between the nurse and the prescriber to ensure safe administration of the medication.

SPECIAL INSTRUCTIONS: Please circle:

- 1. Late arrival:      give on arrival      omit dose(s)
- 2. Field trips:      give as usual      omit dose(s)
- 3. Early closing:    give as usual      omit dose(s)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

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**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL**

The Connecticut State Law, Section 10-212a of the Connecticut General Statutes, State Department of Health, PHN Division, requires a written  
order of a physician or dentist and the written authorization of a parent or guardian of such child for a school nurse or in the absence of such  
nurse, the principal or any teacher to administer medications.

Medications must be in pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, physician's  
or dentist's name, and date of original prescription.

Over the counter medications must be in the original sealed container.

All medications must be brought in and picked up by a legally responsible adult.

**Physician's or Dentist's Order\* TO BE COMPLETED BY PRESCRIBER ONLY**

*\*Please note: order will not be accepted if filled out by parent/guardian*

Health conditions for which drug is being administered during school hours: \_\_\_\_\_  
Drug: name \_\_\_\_\_ dose \_\_\_\_\_  
method of administration \_\_\_\_\_ time \_\_\_\_\_

Permission to give in school if failed to receive dose at home: (circle one) YES NO Dosage: \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_ If yes, DEA number: \_\_\_\_\_

Is this an investigational drug? \_\_\_\_\_

Dates medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Physician/Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician/Dentist Printed Name \_\_\_\_\_