NEWTOWN PUBLIC SCHOOLS

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for administration, and date of the prescription.

Authorized Prescriber's Order

(Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist)

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address_____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES NO

Condition for which drug is being administered _____

Dosage _____Route_____Time of Adminstration_____

Start Date_____/_____/_____End Date _____/_____/_____

Specific Instructions for Medication Administration_____

Permission to give in school if failed to receive dose at home:_____ YES _____ NO

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food/drugs:_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone (_____) _____

Prescriber's Address _____Town_____

PRESCRIBER'S SIGNATURE _____ Date _____/_____/_____

PRESCRIBER'S AUTHORIZATION FOR SELF-ADMINISTRATION

_____

Signature Date

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization

I request that medication be administered to my student as described and directed above. I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only). I understand that this medication will be destroyed if not picked up within one week following termination of order or the last day of school, whichever comes first.

Parent/Guardian Signature_____ Relationship_____ Date _____/_____/_____

Parent /Guardian'sAddress_____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION: _____

Signature Date