Authorization for the Administration of Medication by School 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 medication's 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 of Child/Student _____ Town_____

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

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____
Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

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

Prescriber's Address _____ Town _____
Prescriber's Signature _____ Date ____/____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/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 have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____ Town_____ State____
E-mail: _____ Cell Phone # (____) _____-_____ Other Phone # (____) _____-_____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication specified on this form: _____YES _____NO
2. Student to possess medication specified on this form: _____YES _____NO

Prescriber's Authorization and Signature: _____ Date:_____

Parent/Guardian Authorization and Signature: _____ Date: _____

School nurse (RN) Approval of self-administration (if applicable): _____ Date: _____

Printed Name of Individual Receiving Wwritten Authorization and Medication_____
Title/Position/ _____ Date: _____

Medication Administration Record (MAR)

Name of Child/Student_____ **Date of Birth** _____/_____/_____

Pharmacy Name _____**Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self-Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete** ☐ **Medication is appropriately labeled**

☐ **Medication is in original container** ☐ **Date on label is current**

Person Accepting Medication (print name) _____**Date** _____/_____/___

Regulation 5000
Form #2

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut

AUTHORIZATION FOR THE SELF-ADMINISTRATION OF MEDICINES

Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a student to self-administer medications in school. Medications must be in pharmacy prepared containers and labeled with name of student, name of drug, strength, dosage, frequency, authorized prescriber's name and date of original prescription. The school nurse must evaluate the situation and deem it to be safe and appropriate and develop a plan for general supervision.

Authorized Prescriber's Order

Name of Child _____ Date

Address _____ 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 (date) _____ to (date) _____

Relevant side effect to be observed, if any _____

_____

If there are side effects, plan for management _____

_____

Is this a controlled drug? _____ If yes, DEA number _____

This student has been appropriately instructed regarding self-administration of this medication. I have conferred with this student's parent/guardian and feel that this medication may be self-administered. ☐ Yes ☐ No

Authorized Prescriber's Name _____ Telephone _____

Address _____

Authorized Prescriber's Signature _____ Date _____

Authorization by Parent/Guardian for the self-administration of the above medication

Date _____

I hereby request that the above medication, ordered by the physician/dentist for my child, be self-administered by my child. 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 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. By signing below, I am also authorizing the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of said medication.

Name _____ Signature

Relationship to Child _____ Telephone _____ Address

Nurse/Principal/Teacher _____ Date _____

5000
Form #3

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut

Dear Parent:

For the added safety of students, the Waterford Board of Education has revised policy 5000 on administration of medications to students. The policy covers not only prescribed medication to be taken during the school day (or at a school sponsored event) but also aspirin, aspirin substitutes, and all other over the counter medications.

The policy states that students may take medications at school only after the district's authorization form has been completely filled out, signed by both the student's authorized prescriber and a parent/guardian, and is on file at the school. Permission forms for the administration of medications may be obtained at each school. If you have questions regarding procedures, please contact the principal or school nurse.

The school nurse will administer medications when she or he is on duty; in the absence of the nurse, other qualified school personnel may give medication. The policy also allows students to self-medicate with a written order from their physician/dentist and from their parent/guardian.

Medication, including sample medications, must be delivered by an adult and must be in containers labeled with the name and strength of medication, name of patient, prescribing physician, and directions for taking the medication. No more than a forty-five day supply of medication can be kept at school.

Thank you for your cooperation. We recognize the added problems for parents in adhering to this policy, but the procedures are necessary to comply with State requirements. We will work with you to make compliance as smooth as possible.

Sincerely,

Superintendent of Schools

5000
Form #4

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut

RECORD OF TRAINING OF SCHOOL PERSONNEL IN THE ADMINISTRATION OF MEDICINES

School Building

Responsible School Nurse

PROCEDURAL ASPECTS

Date	Name Principal/Teacher	Storage	Safe Handling and Recording	Specific Student Needs	Medication Idiosyncrasies	Desired Effects	Potential Side Effect Untoward Reactions

Directions: Check (X) when completed.
Copy to Nurse and to Principal of School

5000
Form #5

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut

MEDICATION ERROR REPORT

Date of Report _____ School _____ Prepared by _____

Name of Student _____ Grade

Home Address _____ Telephone

Date Error Occurred _____ Time Noted

Person Administering Medication

Reason Medication was Prescribed _____

Date of Order _____ Instructions for Administration _____

Medication(s)	Dose	Route	Sched. Time	Dispen. Pharm.	Prescription No.

Describe the error and how it occurred (use reverse side if necessary): _____

_____

_____

_____

Action Taken:

Prescribing Practitioner Notified: ☐ Yes ☐ No Date _____ Time _____

Parent Notified: ☐ Yes ☐ No Date _____ Time _____

Outcome: _____

_____

_____

_____

Name: _____
(print or type)

_____ _____ _____
(Signature) Title Date

File in student's cumulative health record.

5000
Form #6

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut
INDIVIDUAL STUDENT MEDICATION RECORD

Student's Name | Grade/Home Room | Physician/Dentist Ordering Medications | Phone Number

ASA or ASA like substitute requested by parent-no MD order

Drug(Name) | Form | Dosage/Time Ordered | Parent's Name | Phone Number

Received From | Date Received

Strength | Route | Administered From (dates) to | Pharmacy | Date to Reorder

Student's Allergies to food/drugs:

Side Effects of Medication to be Observed: | Prescription Number | Prescription date

Received/Checked By | Quantity

Date Mo.-Day- Yr.	Time Given AM	PM	Dose Given	Legal Signature of Nurse/Principal/Teacher Administering Medication	Comments	Amt. Of Control Drug Remaining

File in Student's Cumulative Health Record when medication has been completed or discontinued.

5000
Form #6

INDIVIDUAL STUDENT MEDICATION RECORD (continued)

Student's Name _____ Grade/Home Room _____

Drug (name) _____ Form _____ Dosage/Time Ordered _____

Strength _____ Route _____ Administered from (dates) to _____

Date Mo.-Day-Yr.	Time Given AM	PM	Dose Given	Legal Signature of Nurse/Principal/Teacher Administering Medication	Comments	Amt. Of Control Drug Remaining

File in Student's Cumulative Health Record when medication has been completed or discontinued.

5000
Form #7

WATERFORD PUBLIC SCHOOLS
Waterford, Connecticut

RECORD OF EDUCATION/SUPERVISION FOR
PRINCIPALS/TEACHERS IN MEDICATION ADMINISTRATION

School Year: _____ School Building: _____ Responsible School Nurse: _____

Principal/ Teacher	Students	Date of Education	Medications	Idiosyncrasies	Desired Effects	Untoward Effects	Contraindication	Date of Return Demo	Date of Direct Supervision

To be filed in Nurse's Office

5000
Form #8

WATERFORD PUBLIC SCHOOLS
REFUSAL TO PERMIT ADMINISTRATION
OF EPINEPHRINE FOR EMERGENCY FIRST AID

Name of Child:_____ Date of Birth:_____

Address of Child: _____

Name of Parent(s):_____

Address of Parent(s):_____
(if different from child)

Connecticut law requires the school nurse and other qualified school personnel in all public schools to maintain epinephrine in cartridge injectors (EpiPens) for the purpose of administering emergency first aid to students who experience allergic reactions and do not have prior written authorization of a parent or guardian or a prior written order of a qualified medical professional for the administration of epinephrine. State law permits the parent or guardian of a student to submit a written directive to the **school nurse and school medical advisor** that epinephrine shall not be administered to such student in emergency situations. This form is provided for those parents who refuse to have epinephrine administered to their child. The refusal is valid only for the ***CURRENT*** school year.

I, _____, the parent/guardian of _____,
Print name of parent/guardian Print name of student

refuse to permit the administration of epinephrine to the above named student for purposes of emergency first aid in the case of an allergic reaction.

_____ _____
Signature of Parent/Guardian Date

Please return the completed original form to your child's school nurse.