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 _____