SchoolDistrict:	School:		Grade:	
AUTHORIZATION FO Connecticut State Law and Regulations 10-212(a) registered nurse or physician's assistant) and pare or teacher to administer medication. Medications	ent/guardian written authorization, i	of an authorized prescriber, (ph or the nurse, or in the absence of	ysician, dentist, advanced practice of the nurse, a designated principal	
	Prescriber's Author	<u>orization</u>		
Name of Student:		Date of Birth:		
Address:				
Condition for which drug is being administer	ed:			
Dr ug Name:	Dose:	Route:		
Time of Administration:		If PRN, frequency:		
Relevant side effects: None expecte	d Specify:			
ALLERGIES: NO YES (special	ify):			
Medication shall be administered from:		to		
	Month / Day / Year	Montl	n / Day / Year	
Prescriber's Name/Title:	(Type or print)			
Telephone:	Fax:			
Prescriber's Signature:	Date:	Use for	Prescriber's Stamp	
I hereby request that the above ordered medica than a 45 day supply of medication. I understan order or the last day of school, whichever come	nd that this medication will be destr	THORIZATION sonnel. I understand that I must	supply the school with no more	
Parent/Guardian Signature:		Date:		
Parent's Home Phone #:		Work #:		
SELF ADMIN Self administration of medication may be author with Board policy.	NISTRATION OF MEDICATION rized by the prescriber and parent/g			
Prescriber's authorization for self administration	: Yes No _	Signature	Date	
Parent/Guardian authorization for self administr	ation: Yes No	Signature	Duic	
. a. one oddraidh ddinonzadon toi ooli ddinilliistidi		Signature	Date	
School nurse approval for self administration:	Yes No _			
		Signature	Date	

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