PHYSICIAN AUTHORIZATION TO DISPENSE MEDICATION

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse or administer medications; or, in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, and physician's or dentist's name and date of original prescription.

PHYSICIAN OR DENTIST'S ORDER

Name of Child_____ Date _____
Address_____ DOB:_____

Condition for which drug is being administered during school hours _____
_____
DRUG name, Dose and Method of Administration: _____
_____

Medication shall be administered from _____ to _____
(Date) (Date)
Relevant side effects to be observed, if any _____
_____

If there are side effects, plan for management _____
_____
Is this a controlled Drug? _____ If Yes, DEA number _____

Physician's/Dentist's Name: _____(_____)_____
(Type or Print) Tel No.
Address: _____

Physician's/Dentist's Signature _____Date_____

Nurse/Principal/Teacher _____Date_____

AUTHORIZATION BY PARENT/GUARDIAN for the administration of the above medication by school personnel:

Date_____

To School Personnel:
I hereby request that the above medication, ordered by the physician/dentist 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 a physician or pharmacist and will provide no more than a 45 school day supply of said medication. I understand that 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.

Name: _____
TYPE OR PRINT

Signature: _____ Relationship to child _____
Address: _____

Telephone #(s): _____