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 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 Student ___________________________ Date of Birth____/____/____ Today's Date____/____/____

Address____

Medication Name____ Controlled Drug? YES NO

Condition for which drug is being administered ____

Dosage _____________________________Method/Route ____

Time of Administration _____________ If PRN Frequency____

Medication shall be administered: Start Date ____/____/____ End Date ____/____/____

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 ____

PRESCRIBER'S SIGNATURE: _______________________________________ Date _____/_____/_____

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 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'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.

School nurse, if applicable, approval for self-administration: YES NO ________________________________
Signature Date

Prescriber's authorization for self-administration: YES NO ____
Signature Date

Parent/Guardian authorization for self-administration: YES NO _____________________________________
Signature Date