

Central Christian Academy
Southington, Connecticut

Authorization for Medication Administration by School Personnel

Connecticut State Law requires a written order from an authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only - DP.) and parent/legal guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications. All medications shall be delivered to the school by the parent, guardian, eligible student or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy or in the unopened over the counter packaging. No more than a three month supply of medication may be left at school.

Name of Student: _____ DOB: _____ Grade: _____

Trade Name of Medication: _____ Generic Name of Medication: _____

Dosage: _____ Route of Medication: _____

Frequency/Time in School: _____

Reason for Medication: _____

Possible Side Effects and Management: _____

Known Allergies: _____

Dates to be Administered: From: _____ To: _____ Is this a controlled drug? Yes No

If not a controlled drug, this student is capable and authorized to self-administer this medication: Yes No

If **Yes**, prescriber training is required:

Student has been trained in self-administration of this medication in prescriber's office: Yes No

I do I do not wish that the medication be administered on field trips and shortened days.

Special Instructions: _____

Signature: _____ (Physician/Authorized Prescriber)

Address: _____ Phone: _____ Date: _____

Parent/Legal Guardian or Eligible Student Authorization

I hereby give my permission for qualified school personnel to administer to my child the medication ordered above by his or her authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only- DP.) Any misuse of this medication will result in disciplinary consequences following the Central Christian Academy policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school whichever comes first.

I give permission for the release and exchange of information between the school nurse and authorized prescriber necessary to ensure the safe administration of such medication.

Signature of Parent/Legal Guardian/Eligible Student: _____

Date: _____ Home Phone: _____ Cell Phone: _____

School Nurse Authorization

Self-administration of medication may be authorized by the authorized prescriber and parent/legal guardian/eligible student and approved by the school nurse in accordance with Central Christian Academy policy/procedure.

School Nurse approval for self-administration: { Yes { No _____

RN Signature: _____ Date: _____