School District **Amity** **School** _____ **Grade** _____

SCHOOL MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication. Medications must be in the original properly labeled container. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 2021/2022

The school year is from July 1st- June 30th

Self administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and parent/guardian. All other medications considered for self-administration must be approved by the school nurse in accordance with Board policy to confirm student safety and competency with medication procedure.

Prescriber's Authorization

Name of Student _____ **Date of Birth** _____

Condition for which medication is indicated: _____

Medication Allergies ☐ NKDA ☐ Yes: _____

Medication: & generic name _____ **Dose:** _____ ☐mg ☐puffs ☐amp ☐other **Route:** ☐PO ☐GT / NGT ☐Inhaled ☐with Spacer

Side Effects: ☐Not relevant _____

Time of Administration _____ ☐AM ☐PM

If PRN, frequency, Q_____ Hours

Provider Name & Phone/Fax Numbers (printed or stamped)

Prescribers Authorization for Self-Carry ☐Yes ☐No

Prescriber's Authorization for Self-Administration ☐Yes ☐No

Confirms that the student has been instructed to safely and properly administer this medication

Prescriber's Signature _____ **Date:** _____

Parent/Guardian Authorization

I give my permission to have the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 3 month supply of medication for students who **do not self carry** I understand that this medication will be destroyed if not picked up within one week following discontinuation of the medication or the last day of school, whichever comes **first.**

I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed for the safe administration of this medication and the safe management of the condition for which it is prescribed.

Parent/Guardian Authorization for Self-Carry/Self-Administration as per MD order above ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone# _____ Work/ Cell # _____

School nurse approval for Self Administration ☐NR* ☐Yes ☐No _____

**NR mean Not required for inhalers or cartridge injectors* Signature Date