SCHOOL NURSING SERVICE
Wheeler High School/Middle School
297 Norwich Westerly Road
North Stonington, CT 06359
860-535-0377 x 2102

School District: North Stonington Public Schools **School:** Wheeler HS/MS **Grade:** _____

Authorization for the Administration of Medicine by Authorized School Personnel

Connecticut State Law and Regulations10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization for the nurse or in the absence of the nurse, qualified personnel for schools to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Authorized Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Drug Name: _____ Dose: _____ Route: _____

Condition for which drug is being administered: _____

Time of Administration: _____ If PRN, frequency: _____

Medication required on Field Trips: ☐ No ☐ Yes

Relevant Side Effects: ☐ None Expected ☐ Yes, Specify _____

Allergies: ☐ No ☐ Yes (specify) _____

Medication Shall Be Administered from: _____ to _____
(Month/Day/Year) (Month/Day/Year)

Authorized Prescriber's Name/Title: _____
(Type or Print)

Telephone: _____ Fax: _____

Address: _____

_____

Authorized Prescriber's
Signature: _____ Date: _____

Use for Authorized Prescribers Stamp

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a three (3) month supply medication. I understand that the medication will be destroyed if not picked up within one (1) week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

Parent's /Guardian's Home Phone #: _____ Work: _____

Self-Administration of Medication Authorization/Approval

Self-administration of medication may be authorized by the authorized prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.

Authorized prescriber's authorization
For self-administration: ☐ Yes ☐ No Signature: _____ Date: _____

Parent/Guardian authorization
For self-administration: ☐ Yes ☐ No Signature: _____ Date: _____

School nurse approval
For self-administration: ☐ Yes ☐ No Signature: _____ Date: _____