Mansfield Public Schools School Health Services
Authorization for the Administration of Medicines by School Personnel

Connecticut State law and Regulations 10-212(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, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

THE MEDICATION MUST BE STORED IN THE HEALTH ROOM. A PARENT OR RESPONSIBLE ADULT MUST BRING THE MEDICATION TO THE SCHOOL.

PRESCRIBER'S AUTHORIZATION

Name of child_____ Date_____
Address_____ Date of Birth _____
Condition for which drug is being administered during school hours _____
Drug (name, dose, and method of administration)_____
Time 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 _____
ALLERGIES: _____NO ____YES *(specify)*:
Is this a controlled drug?_____ If yes, DEA number_____
Prescriber's Name _____ Tel. No._____
(Type or Print)
Address: _____ Fax: _____
_____
Prescriber's Signature _____ Date _____

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 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

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

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 in accordance with Board policy.

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