



Written order from an authorized prescriber and parents' permission for the administration of medication by school personnel for the school year 2010-2011

The Connecticut State Law and Regulations require a physician's, dentist's or advanced practice registered nurse's written order *and* a parent or guardian's authorizations for the director, teacher or other trained school personnel (in the absence of a nurse) to administer medications. For CFS *this includes common over-the-counter medications such as Tylenol, Advil and Tums.*

Prescription medications must be in the original pharmacy prepared containers and labeled with the name of the child, name of drug, strength, dosage, frequency, name of prescriber and date of original prescription.

Over the counter medication must be supplied by the parent in the original container and labeled by the parent with the child's name. *CFS does not stock over-the-counter medications.*

The information on this form must be the same as the information on the prescription/non-prescription bottle label or the medication will not be administered.

Part I. To be filled out by physician, dentist, advanced practice registered nurse or physician assistant

1) Name of child (please print): _____ **Date of Birth:** _____

Condition for which drug is being administered during school hours: _____

2) Medication (must match name on label): _____ **Date of Order:** _____

3) Dose: _____ **4) Method of administration:** _____ **5) Time:** _____

Duration of administration - from: (date) _____ to: (date) _____ (not to exceed one year)

Side effects to be observed, if any: _____ see package insert

Plan for management of side effects: call parent call health care provider other _____

Interaction of medication with food: _____ Allergies to food or medications? If YES, list _____

Is this a controlled medication? (check one) **YES** **NO** if **YES**, see reverse side

Permission to give at school after parent notification (check one) **YES** **NO**

Permission for child to self-administer own medication (check one) **YES** **NO**

Licensed Prescriber's Name: (please print) _____ Telephone: _____

Address: _____ Licensed Prescriber Signature: _____

(please see part 2 on reverse)



Part II. Authorization by Parent/Guardian for the administration of the above medication

I hereby request that the above medication, ordered for my child by the physician, dentist or advanced practice registered nurse, be administered by the director, teacher or other trained school personnel. I understand that I must supply the school with the medication in the *original container*, dispensed and properly labeled by a pharmacist. Over the counter medication shall be in the original container and labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or following the end of the session for which the child is enrolled.

I confirm that I have given at least one dose of the medication to my child without any evidence of side effects or adverse reactions. (please initial) _____

I wish the medication to be administered on field trips and shortened days (check one). **YES** **NO**

I authorize CFS staff to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: **YES** **NO**

I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order.

Medication must be delivered to the school office by an adult.

Parent or Guardian Name: (please print) _____

Signature: _____ Date: _____

Relationship to child: _____ Home Telephone No.: _____

For controlled substances, parent and administrator must fill out the following:

Amount/Quantity medication received: _____

Administrator's Printed Name: _____

Administrator's Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Signature of certified teacher/administrator receiving and reviewing this form:

_____ Date: _____