



**Written Order from an Authorized Prescriber and Parent/Guardian Permission
for Administration of Medication by CFS School Personnel – School Year 2011-2012**

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, Benadryl, Tums and cold medicines.*

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 stock a select few over-the-counter medications. They are listed on the Attachment 1 to this form. We can administer these medications, not supplied by the parent, only with the signed approval of the parent and a doctor.*

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)



Name of Child _____

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) _____ *Note: this is not required for Epi-Pen® use.*

I give permission for my child to self-administer own medication (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**

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: _____



Name of Child _____

Written Order from an Authorized Prescriber and Parent/Guardian Permission
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Attachment 1

During the course of the school year your child may come to the office and ask for non-prescription medications / treatments to help relieve symptoms of minor conditions such as poison ivy, headache or bug bite. The following items are normally available in our first aid locker in the school office. CFS does not require that these items be provided by a parent. However, Connecticut law prohibits us from dispensing any medication without written approval from you *and* your child's doctor as indicated on pages 1 and 2 of this form. Please put a check mark next to the medications that you *and* your child's doctor approve of being administered to your child. You **AND** you child's doctor must sign and date below. The administration of these medications is at the discretion of the CFS Staff.

<input type="checkbox"/> Tylenol [®] (Acetaminophen) <input type="checkbox"/> Acetaminophen Elixir <input type="checkbox"/> Acetaminophen Tablets 500 mg <input type="checkbox"/> Acetaminophen Children's Chewable 80 mg	<input type="checkbox"/> Sting Relief Swabs [Benzocaine: 20%]
<input type="checkbox"/> Triple Antibiotic Ointment (wound cleaning)	<input type="checkbox"/> Tums [Calcium carbonate] (indigestion)
<input type="checkbox"/> Calagel, Caladryl or Calamine Lotion (skin irritation relief)	<input type="checkbox"/> California Baby [®] No Fragrance SPF 30+ Sunscreen Lotion*
<input type="checkbox"/> Hydrocortisone Cream 1% (skin irritations)	<input type="checkbox"/> Tick Guard [®] Spray** (Natural Tick Repellant)
<input type="checkbox"/> Hydrogen Peroxide 3% (wound cleaning)	<input type="checkbox"/> Bach Kids Rescue Remedy [®] (natural relief from minor stress)
<input type="checkbox"/> Sterile Eye Wash (eye irritations)	<input type="checkbox"/> Arnica Cream or Gel (Homeopathic treatment for bruises, sprains, and pains)
<input type="checkbox"/> Bactine (minor burn relief)	<input type="checkbox"/> AfterBite [®] Kids (relief from insect bites/itching) [Eucalyptus Oil: 1.3%]
<input type="checkbox"/> Ibuprofen Tablets 100 or 200 mg (pain relief)	<input type="checkbox"/> Ricola Sugar Free LemonMint Throat Drops

* Note: we recommend that you apply sunscreen to your child before school. Teachers are not able to apply sunscreen to *every* student before going outside.

** We recommend checking Tick Guard.

We give permission for a trained CFS staff member to administer medications, as indicated above, in accordance with the label directions and with attention to the relevant side affects also listed on the label of the above medications.

Signature of Parent/Guardian: _____ Date: _____

Signature of Physician: _____ Date: _____