

TOLLAND PUBLIC SCHOOLS SCHOOL HEALTH SERVICES



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PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a **prescription or over-the-counter medication during the school day**, you must follow the guidelines required by Connecticut General Statutes, Sec. 10-212a and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-10. These procedures promote safe practices for students and staff. Please read them carefully.

- 1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorization prescriber (physician, dentist, advanced practice registered nurse, ophthalmologist or physician assistant) using the Authorization for Administration of Medicine by School Personnel (see over). A new order is required each year.
- 2. The authorized prescriber must fill in the information requested on the form:
 - a. Student name
 - b. Name and generic name of medication
 - c. Dosage of medication
 - d. Route, time, frequency of administration
 - e. Indication for medication
 - f. Any potential side effects including overdose or missed dose of medication
 - g. Start and termination dates not to exceed 12 month period
 - h. Written signature of prescriber.
- 3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form.
- 4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student's name, the authorized prescriber's name, and the prescription.
- 5. The medication and completed authorization form must be DELIVERED TO THE SCHOOL NURSE BY A RESPONSIBLE ADULT.
- 6. No more than a 3 month supply may be stored at the school.
- 7. At the end of the school year, medications not picked up by parent or guardian will be destroyed per Sec 10-212a-5-I4i.
- 8. Thank you for your cooperation. Please contact the school nurse at your school if you have any question.

Rev: 12/10 ccg

SchoolDistrict:	Tolland P	ublic Schools	School: _			Gra	de:	
registered nurs	ate Law and se or physici eacher to ac	an's assistant) and parent	ire a written me /guardian writte dications mus	edication orde en authorizat	er of an authorized ion, for the nurse e original prope	prescriber, (physic or in the absence	ONNEL cian, dentist, advanced practic ce of the nurse, a designate ainer and dispensed by	
Name of Stud	dent:				D	ate of Birth:		
Address: _								
Condition for	which drug	is being administered:						
Drug Name: Generic and trade	name					Rou		
Time of Adn	ninistration:				If PRN, freque	ency:		
Relevant sic	de effects:	None expected [Specify: _					
ALLERGIES	S: NO	YES (specify):			· · · · · · · · · · · · · · · · · · ·	····		
		ninistered from:			to			
Valid fo	r maximum of 1	year ————	Month / D	ay / Year		Month / D	Day / Year	
Prescriber's	Name/Title:					···		
			(Type or prin	f)				
Telephone:		F.	ax:					
Address:								
Prescriber's	Signature:		D	ate:		Use for Prescriber's Stamp		
				BDIAN AII	THORIZATION			
picked up wi	thin one wee	above ordered medication	be administered ne order or the l	i by school p ast day of sc	ersonnel. I unders hool, whichever co	mes first. I give pe	cation will be destroyed if not ermission for the exchange of redication.	
Parent/Gua	rdian Signat	ure:				Date:		
Parent's Ho	me Phone #	:			Work #:			
Self adminis		SELF ADMINISTE dication may be authorized l					ne school nurse in accordance	
Prescriber's	authorization	for self administration:	Yes	No _	Sigr	nature	Date	
Parent/Gua	rdian authori:	zation for self administration	: Yes	No _				
	e approval fo	or self-administration: required.	Yes	□No	Sigr	nature	Date	
Can not pre	vent students	s with asthma or cartridge See Sec. 10-212a-2	П ₁₆₂	□ ¹⁴⁰ –	Sigr	nature	Date	

AUTHORIZATION FOR T Connecticut State Law and Regulations 10-212(a) requiregistered nurse or physician's assistant) and parent principal or teacher to administer medication. Me physician/pharmacist.	t/guardian written authorization, for the n dications must be in the original p	rized prescriber, (physician, dentist, ac nurse, or in the absence of the nurs	e, a designated	
	Prescriber's Authorization			
Name of Student:		Date of Birth:		
Address:				
Condition for which drug is being administered:				
Drug Name		Route:		
Time of Administration:	requency:			
Relevant side effects: None expected	Specify:			
ALLERGIES: NO YES (specify):				
Medication shall be administered from:	to			
Valid for maximum of 1 year	Month / Day / Year	Month / Day / Year		
Prescriber's Name/Title:		Γ		
	(Type or print)			
Telephone: F	-ax:			
Prescriber's Signature:	Date:			
		Use for Prescriber's Stamp		
I hereby request that the above ordered medication picked up within one week following termination of the information between the prescriber and the school represent/Guardian Signature:	he order or the last day of school, whicheve	derstand that this medication will be der comes first. I give permission for th		
Parent's Home Phone #:	Work #:			
SELF ADMINIST Self administration of medication may be authorized with Board policy.	RATION OF MEDICATION AUTHORIZ by the prescriber and parent/guardian and		in accordance	
Prescriber's authorization for self administration:	Yes No	Signature Date	<u></u> е	
Parent/Guardian authorization for self administration				
School nurse approval for self-administration: Competency evaluation required.		Signature Date		
Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2	Yes No	Signature Date		

School:

SchoolDistrict: Tolland Public Schools

SRC-1, Rev 4/11: cg

Grade:

AUTHORIZATION FOR TH Connecticut State Law and Regulations 10-212(a) requi egistered nurse or physician's assistant) and parent/ principal or teacher to administer medication. Med hysician/pharmacist.	re a written m guardian writt ications mu	nedication order ten authorization	of an authorized on, for the nurse original prope	l prescriber, (physician e, or in the absence o	, dentist, advanced practic of the nurse, a designate		
Name of Student:	Date of Birth:						
Address:			-				
Condition for which drug is being administered:							
Drug Name: Generic and trade name		De	ose	Route:			
Time of Administration:	If PRN, frequency:						
Relevant side effects: None expected	Specify:		_				
ALLERGIES: NO YES (specify):							
Medication shall be administered from:			to				
Valid for maximum of 1 year —————	Month / Day / Year			Month / Day	/ Year		
Prescriber's Name/Title:			٢	· · · · · · · · · · · · · · · · · · ·			
	(Type or prir	nt)					
Telephone: Fa	x:						
Address:							
			1				
Prescriber's Signature:		Date:		Use for Prescr	ibor's Stamp		
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Parent/Guardian Signature:				Date			
Parent's Home Phone #:			_ Work #:				
SELF ADMINISTR Self administration of medication may be authorized b with Board policy.					chool nurse in accordance		
Prescriber's authorization for self administration:	Yes	No _	Sigr	nature	Date		
Parent/Guardian authorization for self administration:	Yes	No _					
School nurse approval for self-administration:			Sigr	nature	Date		
Competency evaluation required.	Yes	☐ No _					
Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2			Sigi	nature	Date		

SchoolDistrict: Tolland Public Schools School: Grade: