PARISH HILL MIDDLE HIGH SCHOOL
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and regulations require a physician's or dentist's written order and a parent or guardian's authorization for a nurse to administer medications, or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name and date of original prescription.

PHYSICIAN OR DENTIST ORDER:

Name of Child: _____ Date: _____

Address: _____ _____ DOB: _____

_____

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

Drug Name: _____ **Generic Name:** _____

Dose: _____ **Time of Administration:** _____

Medication shall be administered from _____ to _____
(date) (date)

Relevant side effects to be observed, if any: _____

If there are any side effects, plan for management: _____

Is this a controlled drug? ☐YES ☐NO If yes, DEA number: _____

STUDENT MAY SELF ADMINISTER ☐YES ☐NO

Physician's/Dentist's Name: _____
(print or type)

Telephone: _____ Fax: _____

Address: _____

Physician/Dentist's Signature: _____

Date: _____

Nurse/Principal/Teacher Signature: _____

Date: _____

Use for Prescriber's Stamp

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 90 day supply of medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or within one week of the closing of school.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Telephone: _____