GREENWICH PUBLIC SCHOOLS
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require an authorized prescriber's written order and 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 the name of student, name of drug, strength, dosage, frequency, authorized prescriber's name and date of original prescription. Use one form per medication.

AUTHORIZED PRESCRIBER'S ORDER DATE:_____

Name of Student: _____ School: _____
Address:_____ Date of Birth: _____ Allergies _____
CONDITION for which drug is being administered: _____
DRUG NAME: _____ **DOSE:** _____
METHOD of administration: _____ **TIME** of Administration: _____
Medication shall be administered from (DATE): _____ TO: _____
Relevant side effects to be observed, if any: _____
If there are side effects, plan for management: _____
Is this a controlled drug? _____ If yes, DEA number: _____ Is this an investigational drug? _____
AUTHORIZED PRESCRIBER'S NAME: _____ Tel. #: _____
Address: _____ Date: _____
* PRESCRIBER'S SIGNATURE: _____
Please indicate if you feel this student is able to administer his/her own medication (s): Yes _____No: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

I hereby request that the above ordered medication be administered by school personnel and consent to communication between the school nurse and prescriber that are necessary to ensure safe administration of this medication. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a pharmacist, and will provide no more than a 3 month supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order, or one day beyond the close of school in June unless the student will be attending the ESY Program.

*Parent Signature:_____ Date: _____
Address: _____ Telephone #: _____

I would _____ would not _____ like this medication to be administered on field trips.
I would _____ would not _____ like this medication to be administered on early dismissal days.

I hereby give permission for my child to self administer the above medication:
*Parent signature _____ Date: _____
Address: _____ Telephone #: _____

I hereby give permission to my child to carry the above medication on their person:
*Parent signature: _____ Date: _____
Address: _____ Telephone #: _____

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Approved: ___Denied: _____Disagree(Epi/Inhaler):____ *SchoolNurse Signature _____ Date: _____

Self administer: _____ Carry Medication: _____

In order to administer medication in school we must have the above from filled in completely; the medication must be delivered to the nurse by parent/guardian and medication must be in a labeled pharmacy container. If over the counter medication, it must be in an unopened container.

*Original Signatures Only. Stamped signatures not accepted. 01/14

Current Student's Photography

Student's Name:
_____

01/14