

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 #: _____

* * * * *

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.

GREENWICH PUBLIC SCHOOLS
 INDIVIDUAL STUDENT MEDICATION RECORD
 (NON-CONTROLLED MEDICATIONS)

Student Name _____ Grade/Homeroom _____

Practitioner/Dentist _____ Phone No. _____

Drug (Name)	Form	Dosage/Time Ordered
Strength	Route	Administered (dates) From To

Parent's Name _____ Phone No. _____

Received From _____ Date Rec'd _____

Student's allergies to food or drugs:

Pharmacy _____ Date to re-order _____

Side effects of medication to be observed:

Prescriptions # _____ Prescription Date _____

Received & Checked by _____ Quantity _____

DATE Month-Day-Year	TIME GIVEN		DOSE GIVEN	LEGAL SIGNATURE of R.N., Principal/Teacher Administering medication	COMMENTS
	AM	PM			

IF DAILY MEDICATION IS NOT GIVEN, RECORD THE DATE, TIME, INCLUDING THE REASON FOR OMISSION. MAINTAIN THIS RECORD FOR NO LESS THAN THREE (3) YEARS.

File in Cumulative Health record when completed or discontinued, or discard if medication was never given and document in CHR under "Medications comments".