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

The Connecticut State Law requires a written order from a M.D., D.O., D.D.S., A.P.R.N., or P.A. as well as a parent or guardian's authorization for a nurse to administer prescribed or over the counter medications. In the absence of a nurse the principal or teacher may administer medications. Prescribed medications must be in the **original container** dispensed and **properly labeled** by a pharmacist, "over the counter medicines" must be in the original container. No more than a 90-day supply of medication may be left at school. Inhalant medications may be self-administered with the approval of the school nurse. The M.D. or authorized prescriber and parent/guardian must authorize self-administration.

NAME OF STUDENT:______________________________ D.O.B.:________ GRADE:________

KNOWN ALLERGIES:______________________________ History of Anaphylactic Reaction: Y N

REASON FOR MEDICATION: ____

*NAME OF MEDICATION: ______________________________________ DOSAGE:__________
(BRAND) (GENERIC)

*ROUTE OF MEDICATION: _____SAMPLE:___YES___NO CONTROL DRUG: YES___NO___

*FREQUENCY:______________________________ TIME TO BE GIVEN IN SCHOOL:__________

*PERMISSION TO GIVE IN SCHOOL IF FAILED TO RECEIVE DOSE AT HOME:___YES___NO

*SIDE EFFECTS AND PLAN FOR MANAGEMENT:______________________________________

*LENGTH OF TIME DURING WHICH DRUG IS TO BE ADMINISTERED:
(DATES) FROM____________________________ TO____________________________

*IS THIS STUDENT CAPABLE OF SELF-ADMINISTERING THE DRUG:_____YES_____NO

*SPECIAL INSTRUCTIONS:____

*DATE:________________ SIGNATURE:______________________________________
PHYSICIAN OR AUTHORIZED PRESCRIBER DEA#

ADDRESS:______________________________ PHONE:__________

***Must be completed by the AUTHORIZED PRESCRIBER only!**

AUTHORIZATION OF PARENT OR GUARDIAN

***The above information may be released to my child's school.**
I hereby give my permission for my child to receive the medication ordered above by his/her M.D., D.O., D.D.S., A.P.R.N., or P. A. I also understand that I am giving permission for the exchange of information between prescriber and the school nurse necessary to ensure safe administration of the medication. Medication is to be administered by:
___ Nurse or Trained School Personnel ___ Student May Self-Administer
I HAVE READ THE FOOD ALLERGY MANAGEMENT POLICY.
I **DO/ DO NOT** (circle one) wish the medication administered on field trips and shortened school days.
I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school, whichever comes first.
MEDICATION MUST BE DELIVERED TO THE SCHOOL NURSE BY AN ADULT.

DATE:________ SIGNATURE OF PARENT/GUARDIAN:____________________ PHONE:________

NMS Health Office FAX: 203-270-4553