

**BROOKFIELD PUBLIC SCHOOLS
BROOKFIELD, CONNECTICUT 06804**

**AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATIONS BY
SCHOOL PERSONNEL**

The Connecticut State Law and Regulations require an M.D., D.D.S., O.D., A.P.R.N., or P.A.C.'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 medication.

THE INFORMATION ON THIS FORM MUST BE THE SAME AS THE INFORMATION ON THE PRESCRIPTION BOTTLE LABEL OR THE MEDICATION WILL NOT BE ADMINISTERED.

PRESCRIBER'S ORDER

Name of Child _____ Grade _____ DOB _____

Condition for which drug is being administered during school hours _____

DRUG: Name, dose and method of administration _____

Duration of administration _____ to _____
(date) (date)

Is this a sample medication? YES NO (circle one) Lot# _____

Is this a controlled drug? _____ If yes, DEA number _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Permission to give at school if failed to receive dose at home: YES NO (circle one)

Authorized Prescriber's Name (print) _____

Telephone () _____ (FAX) _____

Authorized Prescriber's Signature _____ Date _____

**AUTHORIZED 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 M.D., O.D., D.D.S., A.P.R.N., or P.A.C. for my child be administered by school personnel. ***A limit of a 45 school day supply of medication will be accepted. Medication must be supplied in the original prescription container. Ask the pharmacist for two completely labeled containers, providing one for the home and one for the school.***

I **DO / DO NOT** (circle one) wish the medication administered on field trips and shortened days.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

MEDICATION MUST BE DELIVERED TO THE SCHOOL NURSE BY AN ADULT.

Name: (print) _____ Date _____

Signature: _____ Relationship to child: _____

Telephone: (H) _____ (W) _____