Cooperative Educational Services
Division of Special Education
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law requires:

1. The written order of an MD, OD, DDS, APRN, or a PA for **prescription and non-prescription** medications.
2. Written authorization from the parent/guardian for medications, (including **prescription and non-prescription**) to be administered by school personnel.
3. **Medication must be stored in the original container.**
4. All medications, **except those approved, in advance by the school nurse,** for transporting by students for self-medication, must be delivered to the school by the parent/guardian or other responsible adult.
5. No more than a 45-day supply of medication may be left at school.
6. Inhalant medications may **only** be self-administered at all grade levels with the approval of the school nurse.
7. Self-administration must be authorized by the school nurse, as well as, the prescribing practitioner and parent/guardian.

Section A: (Completed by Physician or Authorized Prescriber)

Name of Student_____DOB_____Program_____

Known Allergies_____

Name of Medication and Dosage_____

Route of Administration_____Frequency_____

Time(s) to be given_____ Samples: Yes_____ No_____

Medication shall be administered from: _____to _____
(Please give dates)

Reason for the Medication_____
Permission to give in school if failed to receive dose at home: (please circle one) Yes No N/A
Side Effects and Plan for Management_____
_____
Is the Student capable of self-administering? (please circle one) Yes No N/A
Special Instructions_____
_____
Is this a controlled drug?_____ If yes, please give DEA number_____

Printed Name of Prescriber _____

Address_____Phone_____

_____FAX_____

Signature of Physician or Authorized Prescriber_____ Date _____

Section B: (Completed by Parent)

Authorization of Parent/Guardian/Responsible Student

I hereby give permission for the student to receive the medication ordered above by his/her Physician or Approved Provider
Medication is to be administered by: ☐ Nurse or Trained Personnel OR ☐Student may Self-administer (must be authorized by School Nurse in advance)

I wish or I do not wish the medication administered on field trips and shortened school days.
(please circle one)

I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order or by the last day of school, whichever comes first.

Signature of Parent/Guardian*_____
Address_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

*Signature is required if a student is younger than 18 years of age or if student is 18 years of age or older and guardianship has been obtained by parent/other.