OXFORD PUBLIC SCHOOLS
SCHOOL MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician’s assistant, and for interscholastic and intramural sports, only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication. Medications must be in the original properly labeled container. Prescription medication should be in the labeled container dispensed by a pharmacist.

This authorization is in effect for the school year: 2016 - 2017

Self-administration of asthma inhalers and cartridge injectors (for medically diagnosed allergies) may be authorized by the prescriber and parent/guardian. All other medications considered for self-administration must be approved by the school nurse in accordance with Board policy to confirm student safety and competency with medication procedure.

Prescriber’s Authorization

Name of Student __________________________________________ Date of Birth ______________________

Condition for which medication is indicated: __________________________ Medication □ NKDA

Allergies □ Yes: __________

Medication: ______________________________________________ & generic name __________________________ Dose: __________ □ mg □ amp □ puffs □ GT/NGT

Route: □ PO □ GT/NGT □ Inhaled □ Injected

Time of Administration: ___________ □ AM □ PM Side Effects: ______________________________________________

If PRN, frequency. Q __________ Hours

Prescriber’s Authorization for Self-Administration □ Yes □ No Provider Name & Phone/Fax Numbers (printed or stamped)

Confirms that the student has been instructed to safely and properly administer this medication

Prescriber’s Signature: __________________________________________ Date: ______________________

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 3 month supply of medication. I understand that this medication will be destroyed if not picked up within one week following discontinuation of the medication or the last day of school, whichever comes first.

I also give my consent for the exchange of information between the prescribing health care provider and school nurse, as needed, for the safe administration of this medication and the safe management of the condition for which it is prescribed.

Parent/Guardian Authorization for Self-Administration □ Yes □ No

Parent/Guardian Signature: __________________________________________ Date: ______________________

Parent’s Home Phone#: __________________________________________ Work/Cell #: ______________________

School nurse approval for Self Administration □ NR* □ Yes □ No

Signature ______________________ Date ______________________

*NR means Not required for inhalers or cartridge injectors

Appendix A: Rev 4/2011