TOLLAND PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

TOLLAND HIGH SCHOOL
Cynthia Davidson, R.N., BSN
860 870-6838 FAX 860 870-6839

TOLLAND INTERMEDIATE SCHOOL
Stephanie Lentocha, R.N., BS
860 870-6891 FAX 860 872-7126

TOLLAND MIDDLE SCHOOL
Christine Grulke M.S.R.N., NCSN
860 870-6868 FAX 860 870-5737

BIRCH GROVE PRIMARY SCHOOL
Laura Dolcelli R.N. BSN
860 870-6755 FAX 860 870-6754

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a **prescription or over-the counter medication during the school day,** these are the guidelines required by Connecticut General Statutes, Sec. 10-21a and Connecticut Administrative Regulations, Sec 10-212a-1 through 10-21a-10. These procedures promote safe practices for students an staff. Please read them carefully.

1. For each medication that must be administered daily r on as as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, ophthalmologist or physician assistant) using the Authorization for Administration of Medicine by School Personnel (see other side) A new order is required each year.

2. The authorized prescriber must fill in the information requested on the form:

   a. Student Name
   b. Name and generic name of medicine
   c. Dosage of medication
   d Route, time, frequency of administration
   e. Indication for medication
   f. Any potential side effects including overdose or missed dose of medication
   g. Start and termination dates not to exceed 12 month period
   h. Written signature of prescriber

3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form

4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, Clearly labeled with the student's name, the authorized prescriber's name, and the prescription.

5. The medication and completed authorization form must be **DELIVERED TO THE SCHOOL NURSE BY A RESPONSIBLE ADULT.**

6. No more than a **3 month supply** may be stored at the school.

7. At the end of the school year, medication not picked up by parent or guardian will be destroyed per Sec 10-212a-5-I4i.

8. Thank you for your cooperation. Please contact the school nurse at your school if you have any questions.

Rev 5/14 ccg

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/___

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____ Signature _____ Date

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)