Authorization for the Administration of Medication by Plymouth Public School Personnel

In Connecticut schools 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 school with the appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for the medication's administration, and the date of the prescription.

Authorized Prescriber's Order: (Physician, Dentist, Optometrist, Physician Assistant, APRN or Podiatrist):

Name of Student ____ D.O.B._____/_____/_____ Today's Date _____/_____/_____

Address of Student ____ Town ___________________________

Medication Name ____ Controlled Drug? ☐ Yes ☐ No

Condition for which drug is being administered ____

Specific Instructions for Medication Administration ____

Dosage ____________________ Route ________________ Time of Administration (if prn, frequency)________ _______________

Medication shall be administered from: start date: _______/_______/_______ End Date: _______/_______/_______

Relevant Side Effects of Medication ____ ☐ None Expected

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

Prescriber's Name/Title ____ Phone Number (________)____________________

Prescriber's Address ____ Town ________________________________

Prescriber's Signature ____ Date __________________

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above by school personnel. I give permission for the exchange of information between the prescriber and the school nurse 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.

Parent/Guardian Signature __________________________________ Relationship _________________ Date _____/_____/______

Parent/Guardian Address (if different than above)____

List phone contact number(s) in order you want to be called____

Self Administration and/or Possession 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.

Student to self-administer medication specified on this form : ☐YES ☐NO

Student to possess medication specified on the form:: ☐YES ☐NO

Prescriber's Authorization and Signature ____ Date_______________

Parent/Guardian Authorization and Signature ____ Date_______________

School Nurse (RN) Approval of Self-administration (if applicable) ____________________________________ Date_______________

Today's Date ________________________ Signature: ____

Of Individual Receiving Medication

Printed Name ____ Title/Position ____________________

Form date 3/01/2020

Plymouth Public Schools
School Health Services MAR
(for use as a downtime record or by non nurse delegated to administer medication)

Training regarding specific information related to this student's medication and medication plan has been provided to the following authorized school personnel including but not limited to:

- Name of Medication and Indications for Medication
- Medication Dosage, Routes, Times, and Frequency of Administration
- Therapeutic Effects of Medication and Potential Side Effects
- Overdose and Missed Dose Effects and Emergency Interventions Implementation
- The 5 rights of Medication Administration
- Safe handling/storage and Documentation/Recording

- ❏ General Medication and Epi-Pen Administration sheet provided
- ❏ Individual Glucagon Training Provided and/or reviewed

Location of Field Trip/Club: ____ Date(s): ____________________

Signature of nurse providing instruction : ____

Special Instructions: ____

____
Signature of Authorized School Staff Member

Medication Administration Record for Field Trip/Club:
(to be completed if above medication is administered on the field trip or at club)

Date:	Time:	Dosage:	Self-Administered	Signature of Person Observing or Administering	Remarks
			☐Yes ☐No		
			☐Yes ☐No		
			☐Yes ☐No		

Documentation of refills: Quantity:_______________________

Signature of person Delivering med: ____ Date:_______________

Signature of Person Receiving Medication: ____

Medication Return: (for discontinued medications or unused portions at the end of the school year)

Signature of person receiving medication: ____ Date:_______________

Witness:(print name and position)____ Date: _______________