Academy of the Holy Family

54 W Main Street * P O Box 691 * Baltic CT * 06330-0691
School (860) 822-9272 * FAX (860) 822-1318
E-mail: schoolnurse@ahfbaltic.org

Prescription Medication Authorization by School Personnel

(MUST USE A SEPARATE FORM FOR EACH MEDICATION)

(To Be Renewed Yearly and When Dose Changes Throughout the Year)

ALL INFORMATION MUST BE IN ENGLISH
(Immediate family member may not sign as the authorized prescriber)
Original form must be sent to AHF – Keep a copy for your record

*Connecticut State Law and Regulations 10-212(a) requires that **written authorization** from an **authorized prescriber**, i.e., **Physician (MD), Dentist, or Advanced Practice Registered Nurse (APRN), Physician's Assistant (PA)** and parent/guardian written authorization, for the nurse, health aide, or in the absence of the NURSE, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist* during the current school year **20 ____ - 20 ____.**

Prescription medication must be in the original pharmacy prepared container, pharmacy label with name of student, drug, strength, dosage, frequency, prescriber's name, and date of original prescription.

PRESCRIBER'S AUTHORIZATION

Name of Student: _____ **Date of Birth:** _____ / _____ / _____
(Month Day Year)

Address: _____

_____

Condition for which Medication is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency_____

Relevant side effects: ☐ None expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (specify): _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

PRESCRIBER'S SIGNATURE: _____ Date: _____

Is this a Controlled Drug: Yes _____ No _____ If, yes, provide DEA number: _____

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

PARENT'S OR GUARDIAN'S SIGNATURE: _____ Date: _____

Parent/Guardian Home Phone #: _____ Cell #: _____ Work #: _____

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by school health aide/nurse in accordance with Board policy.

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

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

School Nurse approval for self-administration: ☐ YES ☐ NO _____
Signature Date

Student has permission to carry and self-administer: ☐ **Epi-Pen** ☐ **Inhaler** ☐ **Diabetic Medication**

NAME OF AUTHORIZED PRESCRIBER: _____ Date: _____

PRESCRIBER'S SIGNATURE: _____ Phone No: _____