FIELD TRIP Medication Authorization Form

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212 (a) require a written medication order completed by an authorized prescriber, (physician, dentist, advanced practice nurse, or physician assistant) and parent/guardian written authorization. for the nurse, or in the absence of the nurse, a designated principal or teacher to administer all medication, even over the counter medications.. All medication must be in the original properly labeled container and if prescription medication, dispensed by a physician, in an original pharmacy bottle

PRESCRIBER'S AUTHORIZATION

Student: *Date of Birth*

Address

ALLERGIES ☐ NO ☐ YES(*specify)* ->

Medication: Name: Dose: Route

Time of administration:

Relevant side effects to be observed, if any:

Condition for which drug is being administered:

Medication: Name: Dose: Route

Time of administration: If PRN, frequency

Relevant side effects to be observed, if any:

Condition for which drug is being administered:

Medication: Name: Dose: Route

Time of administration: If PRN, frequency

Relevant side effects to be observed, if any:

Condition for which drug is being administered:

Medication: Name: Dose: Route

Time of administration: If PRN, frequency

Relevant side effects to be observed, if any:

Condition for which drug is being administered:

MEDICATION SHALL BE ADMINISTERED FROM: *to*

Month / Day / Year ***Month / Day / Year***

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

Address:

Telephone: Fax

Prescriber's Signature: *Date* *Prescriber's Stamp*

SELF-ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self administration of the above ordered medication may be authorized by the prescriber and parent/guardian and must be approved by the school 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*

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 the prescribed medication for this trip. 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/Guardian Name *Signature* *Date*

Parent/Guardian Phone: Home *Work* *Cell*