

**GRANBY MEMORIAL SCHOOL DISTRICT
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION**

Name of Student: _____

DOB: _____

Grade: _____

MEDICATION ORDER

(To be completed by authorized prescriber)

Condition for which drug is being administered: _____

Name of Medication: _____ Dose: _____ Route: _____

Frequency: PRN every ____ hour ____ minutes; Before Exercise ____ minutes Scheduled at _____ am pm.

Comments: _____

Relevant Side Effects: None Expected Specify: _____

ALLERGIES: NO YES Specify: _____

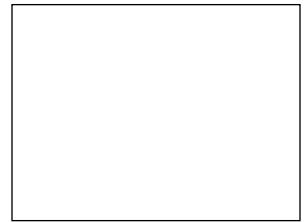
Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber Name/Title: _____

Printed Name and Title

Telephone: _____ Fax: _____

Address: _____



Use for Prescriber's Stamp

*This medication is NOT a controlled substance and this student is authorized to carry and self administer the above prescribed medication: YES NO

Prescriber's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require written medication order of an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) and parent/guardian written authorization, for the nurse, 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.

Parent/Guardian: Initial the appropriate box(s) and provide a signature below.

- I hereby authorize 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 in the original properly labeled container. 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.
- I hereby authorized my child to self carry and administer the above prescribed medication.
 - I understand that my child is responsible for self carry and administration according to the prescribing practitioner and will carry the medication in the original properly labeled container on his/her person to be taken only as prescribed during school hours to include field trips and after school activities.

Parent/Guardian Signature: _____ Date: _____

STUDENT AGREEMENT

I hereby accept the responsibility to carry and self administer the above prescribed medication while in school and during school activities. I understand that I will not share my medication with anyone else and will keep it safely stored in a properly labeled container available only to my person. ***Nurse will check box below if applicable:**

- * I understand that I am to report to the school nurse after I have administered my prescribed emergency medication.

Student Signature: _____ Date: _____

Approved Not Approved Nurse's Signature: _____ Date: _____