# 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: _____

Revised: 4/27/06