



TOLLAND PUBLIC SCHOOLS

SCHOOL HEALTH SERVICES



TOLLAND HIGH SCHOOL
Michelle Povilonis RN
860 870-6838 FAX 860 870-6839

TOLLAND MIDDLE SCHOOL
Christine Grulke M.S.R.N., NCSN
860 870-6868 FAX 860 870-5737

TOLLAND INTERMEDIATE SCHOOL
Kitty Warren RN
860 870-6891 FAX 860 872-7126

BIRCH GROVE PRIMARY SCHOOL
Laura Dolcelli RN, BSN
860 870-6755 FAX 860 870-6754

PROCEDURE FOR REQUESTING MEDICATION ADMINISTRATION

If your child requires a **prescription or over-the-counter medication during the school day**, you must follow the guidelines required by Connecticut General Statutes, Sec. 10-212a and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-10. These procedures promote safe practices for students and staff. Please read them carefully.

1. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorization prescriber (physician, dentist, advanced practice registered nurse, ophthalmologist or physician assistant) using the Authorization for Administration of Medicine by School Personnel (see over). A new order is required each year.
2. The authorized prescriber must fill in the information requested on the form:
 - a. Student name
 - b. Name and generic name of medication
 - c. Dosage of medication
 - d. Route, time, frequency of administration
 - e. Indication for medication
 - f. Any potential side effects including overdose or missed dose of medication
 - g. Start and termination dates not to exceed 12 month period
 - h. Written signature of prescriber.
3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form.
4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student's name, the authorized prescriber's name, and the prescription.
5. The medication and completed authorization form must be **DELIVERED TO THE SCHOOL NURSE BY A RESPONSIBLE ADULT**.
6. No more than a **3 month supply** may be stored at the school.
7. At the end of the school year, medications not picked up by parent or guardian will be destroyed per Sec 10-212a-5-14i.
8. Thank you for your cooperation. Please contact the school nurse at your school if you have any question.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a 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.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose _____ Route: _____
Generic and trade name

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (specify): _____

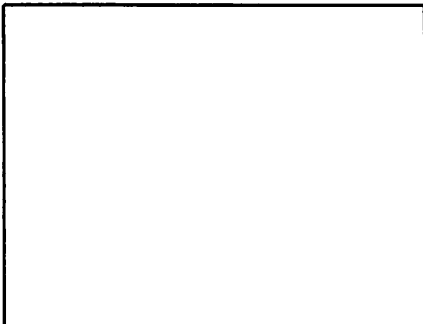
Medication shall be administered from: _____ to _____
Valid for maximum of 1 year Month / Day / Year Month / Day / Year

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

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____



Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. 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 give permission for the exchange of information between the prescriber and the school nurse when necessary to ensure the safe administration of such medication.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ 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 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:
Competency evaluation required.
Can not prevent students with asthma or cartridge injectors from self carry. See Sec. 10-212a-2
 Yes No _____
Signature Date

School District: Tolland Public Schools School: _____ Grade: _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a 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.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose _____ Route: _____
Generic and trade name

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (specify): _____

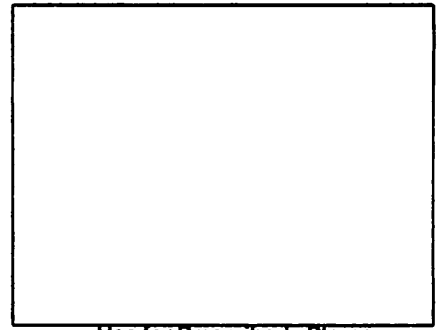
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Valid for maximum of 1 year Month / Day / Year Month / Day / Year

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

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____



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Signature Date

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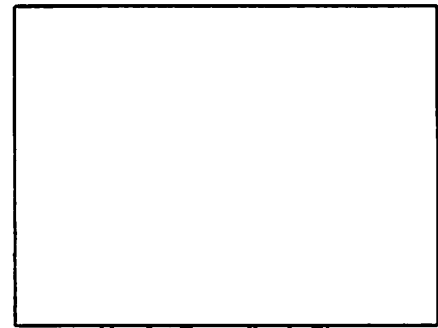
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