TOWN OF MANCHESTER
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY PERSONNEL

Connecticut State law requires a written order from a licensed physician or dentist along with a permission form from a parent/guardian in order for school/camp personnel to be able to administer over the counter and prescription medication to a student. For the safety of all concerned, medication to be administered through the school/camp be delivered to the school/camp nurse by a parent, guardian or a designated responsible adult, and be in the original, labeled container that it was dispensed or purchased in. In the absence of the school nurse, the principal, or teacher will administer the medication or; at a camp program, Discovery Camp staff or Manchester Park and Recreation staff, will administer the medication.

PHYSICIAN OR DENTIST'S ORDER

Name of Child _____ Date _____

Address _____ Date of Birth _____

Condition for which drug is being administered during school hours _____

_____

DRUG: Name, dose and frequency of administration _____

_____

Time of administration _____

Medication shall be administered from _____ to _____
(Date) (Date)

Relevant side effects to be observed, if any _____

_____

If there are side effects, plan for management _____

_____

Is this a controlled drug? Yes _____ No _____ If yes, DEA number _____

This student has been evaluated and is deemed to be capable of self-administration of the medication _____ Yes _____ No

Physician/Dentist's Name _____ Telephone _____

Address _____

Physician's or Dentist's Signature _____ Date _____

Nurse/Principal/Teacher/Camp Staff _____ Date _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY SCHOOL/CAMP PERSONNEL:

To School/Camp Personnel:

I hereby request that the above medication, ordered by an authorized prescriber be administered to my child, _____ by school/camp personnel only. I understand that I must supply the school with the prescribed medication in the original container, dispensed and properly labeled, with student and prescriber's name, name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription. I will provide no more than a 45 school day supply of the said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order, or one week beyond the close of school/camp.

I give my consent for verbal and/or written communication between my child's health care provider and the school/camp nurse for treatment/medication related purposes.

SPECIAL INSTRUCTIONS FOR STUDENTS TAKING MEDICATION AT SCHOOL: Please check the appropriate box for each of the numbered situations:

1. Late Arrival: ☐ give meds upon arrival at school ☐ omit dose(s)
2. Early Closing: ☐ give meds as scheduled ☐ omit dose(s)
3. Field Trips: ☐ give meds as scheduled ☐ omit dose(s)
4. Self Medication: ☐ I give permission for my child to self medicate, and have reviewed the requirements with the school/camp nurse

Name: _____ Relationship to Child: _____

Signature: _____ Address: _____

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