SAINT JAMES SCHOOL

INSTRUCTIONS TO PARENTS FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

It is advisable to have students take medications at home whenever possible. However, if your health care provider feels it is necessary for your child to take medication during school hours, Connecticut law and regulations require (1) a written order from a physician, dentist, advance practice registered nurse, or physician assistant and (2) written authorization/permission from the parent/guardian. This requirement applies both to medications available over-the-counter AND to those available only by prescription.

The following steps must be taken in order to have your child receive/take medications in school:

1. Obtain a "Medication Authorization Form" from the school nurse as soon as you are aware that medication needs to be given during school hours. If you do not have the form with you at the time of your visit, your health care provider may write the instructions on his/her prescription pad, to be stapled to this form.

2. You must fill in the section of the form entitled "Parent/Guardian Authorization."

3. *All medications must be delivered by the parent or other responsible adult to the school nurse/substitute nurse. Do not send medication to school with a student, unless that student has a written order to carry his/her medication for health reasons.*

4. If the student is to take his/her own medication (self-administration) or needs to carry his/her medication with him/her for health reasons, this must be indicated on the "Medication Authorization Form." Students self-administering medications must do so in the presence of the school nurse, EXCEPT those students authorized to carry medications on their person for health reasons. The student must inform the school nurse each time s/he self administers medications outside of the nurse's presence.

5. The school will receive only the amount of medication needed, up to a 45-day supply, in a container which has been properly labeled by the pharmacist or manufacturer with the name and strength of the drug. The pharmacy label will show the following information:

    a. Student's name
    b. Prescribing provider's name.
    c. Name of medication
    d. Dosage
    e. Frequency / time of administration

6. Medication orders are valid for up to one school year, and must be renewed at least annually. Medication orders must also be renewed if a student undergoes an operative procedure, or has a significant change in health status; Parental authorization is valid for up to one school year, and must also be renewed with prescribing provider's renewal.

7. No medication of any type will be given to a student without a written prescription. Parents/guardians may come to school to give a medication personally until written orders are received.

AUTHORIZATION FORM ON REVERSE-SIDE.
PLEASE HOLD ONTO THIS FORM FOR FUTURE USE.

ST. JAMES SCHOOL
Stratford, Connecticut

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL
Connecticut State Law and Regulations 10-212(a) and Board of Education policy requires the following:

1. **-a written medication order** from a licensed Medical Doctor (MD), Osteopathic Doctor (OD), Dentist (DDM or DDS), Advanced Practice Registered Nurse (APRN), or Physician Assistant for prescription and "over-the-counter" (nonprescription) medication which needs to be given in school.
2. -written **parental/ guardian consent** for medication administration in school.
3. - **delivery** of medication to the school nurse **by a responsible adult,** preferably the parent/ guardian.
4. - **medication in the original container with proper labeling** [name of medication, student's name, dosage and frequency of administration., time or conditions of use].
5. **-approval by the school nurse,** in addition to the written authorizations, **for self-administration** of medications in school.

MEDICAL AUTHORIZATION

NAME OF STUDENT _____ D.O.B. _____ DATE: _____

MEDICATION NAME _____ DOSAGE _____

ROUTE OF ADMINISTRATION _____ FREQUENCY/CONDITIONS OF USE _____

CONDITION REQUIRING MEDICATION _____ ALLERGIES _____

SIDE EFFECTS TO BE NOTED AND MANAGEMENT PLAN _____

MEDICATION TO BE ADMINISTERED FROM (DATE) _____ TO (DATE) _____

Permission to give in school if dose missed at home. (Please circle one). Yes No

Student may *self-administer* medication *with supervision.* (Please circle one.) Yes No

Student may *self-administer* medication *without supervision* after school nurse has confirmed that student knows indications for medication and proper administration techniques. (Please circle one.) Yes No

PRESCRIBER'S NAME/ TITLE_____ PHONE _____

ADDRESS OF PRESCRIBER _____

PRESCRIBER'S SIGNATURE _____ DATE) _____

PARENT/ GUARDIAN AUTHORIZATION

1. I request that the above ordered medication be administered by school personnel.

2. 1 understand that I may bring only a 45 day supply of medication to school and it is my responsibility to pick up the medication at the end of the school year or within one week following the termination of the medical order.

3. I would or *would not* like this medication to be administered on field trips or early dismissal days.

PARENT/ GUARDIAN NAME_____ PHONE NUMBER (h/c) _____

PARENT/ GUARDIAN SIGNATURE _____ PHONE (w) _____