REGIONAL SCHOOL DISTRICT #17 SCHOOLS
HADDAM KILLINGWORTH MIDDLE SCHOOL WASHINGTON DC MEDICATION FORM
FOR MEDICATION ADMINISTERED FROM May 1-3 2019

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:**_____

PRESCRIPTION MEDICATIONS

1. **Name of Drug:** _____ **Condition for which drug is being Administered:** _____
   Dose: _____ **Route:** _____ **Time of Administration:** _____ **If PRN, frequency:** _____
   Relevant Side Effects if any: _____

2. **Name of Drug:** _____ **Condition for which drug is being Administered:** _____
   Dose: _____ **Route:** _____ **Time of Administration:** _____ **If PRN, frequency:** _____
   Relevant Side Effects if any: _____

3. **Name of Drug:** _____ **Condition for which drug is being Administered:** _____
   Dose: _____ **Route:** _____ **Time of Administration:** _____ **If PRN, frequency:** _____
   Relevant Side Effects if any: _____

4. **Name of Drug:** _____ **Condition for which drug is being Administered:** _____
   Dose: _____ **Route:** _____ **Time of Administration:** _____ **If PRN, frequency:** _____
   Relevant Side Effects if any: _____

OVER THE COUNTER MEDICATIONS

PLEASE CHECK THOSE THAT YOU ARE AUTHORIZING FOR STUDENT

- ○ **Ibuprofen 200 mg tabs 2 tabs PO every 6 hours PRN for c/o headache, fever or pain.**
- ○ **Tums Regular Strength 500 mg chew 2 tabs PO up to three times a day PRN for c/o upset stomach/indigestion**
- ○ **Dramamine 50 mg 1-2 tablets PO every 4-6 hours PRN for c/o motion sickness (Max 8 tabs in 24 hrs)**
- ○ **Claritin 10 mg 1 tablet PO daily for c/o seasonal allergy symptoms**
- ○ **Lactaid 1-2 caplets PO with consumption of dairy**

Prescriber's Name/Title:_____ **Telephone:**_____
****Prescriber's Signature:**_____ **Date:**_____
School Nurse Signature:_____ **Date:**_____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with the prescription medication to cover the trip. I understand that this medication will be destroyed if not picked up within one week following the trip.
Parent/Guardian Signature:_____ **Telephone:**_____ **Date:**_____

SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

In the case of inhalers for asthma and cartridge injectors for medically diagnosed allergies, students may self-carry with written authorization of an authorized prescriber and written authorization from the student's parent/guardian.
Prescriber's signature authorizing self-administration:_____ **Date:**_____
Parent/Guardian's signature authorizing self-administration:_____ **Date:**_____