Dear Parents/Guardian:

At this time of the school year it is important that we review state law and school board policy relative to the administration of medication to students in the public schools. Section 10-212A of the General Statutes provides that, in the absence of the school nurse, a principal or a teacher may administer medicinal preparations when there is written authorization from a physician and written approval given by a parent.

If your child is required to take medication during school hours, written authorization must be given by the child’s physician. Please complete the form Authorization for the Administration of Medicines by School Personnel, including MD orders and signature. Return the form to the school nurse with the medication. Please note:

1. Medication must be in the original container. If it is a prescription medication, it must be in the original prescription bottle with the pharmacy label intact.
2. Medication must be brought to school by a parent or other responsible adult. Students are not permitted to carry medications in to school.
3. All medications are stored in the health room.

Non-medicated chapstick or vaseline may be self-administered by your child. All-natural cough drops are considered hard candy and are subject to individual classroom rules. Motrin, Advil, Tylenol, cough drops, throat lozenges, medicated lip cream, medicated lotions, etc. are all considered medications even though they are over the counter. Therefore, students are not authorized to carry these in school.

If your child has a food allergy or other severe allergy that may require medical attention, please notify the school nurse immediately. The following forms must be completed, signed by a parent/guardian and physician and returned to the health office as soon as possible.

FES new standing orders advised by DR. Schoon indicate that Tylenol per child’s age and weight will only be administered for a fever of 100 or greater. If you feel your child needs an order for Tylenol or Motrin for headaches or generalized discomfort it is your responsibility to complete the attached medical authorization form with your doctor and to supply the medication. As always, if you have any questions or concerns contact the health office at 860-642-7063. Thank you.

Sincerely,
Sheri Salpietro RN  Bob Austin
FES School Nurse  Principal
FRANKLIN PUBLIC SCHOOL
Franklin, Connecticut

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES
BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's, dentist's, advanced practice registered nurse or physician's assistant's written order and parent or guardian's authorization for a nurse to administer medications or in her absence the principal, teacher, licensed physical or occupational therapist of a school or a coach to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription.

PHYSICIAN OR DENTIST'S ORDER

Name of Child ________________________________ Date ___________

Date of Birth ________________________________________________

Allergies to Medications ________________________________________

Condition for which drug is being administered during school hours ____________

DRUG: ________________________________________________________
(name, dose and method of administration)
This medication may be self-administered. ________________________________ Physician's signature
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? __________ If yes, DEA number ________________
Physician's/Dentist's Name __________________________ Telephone _______

Address _______________________________________________________

Physician or Dentist's Signature __________________________ Date ___________

Nurse/Principal/Teacher __________________________________________ Date ___________

AUTHORIZATION BY PARENT / GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE
MEDICATION BY SCHOOL PERSONNEL: __________________________ Date ___________

To School Personnel:

I hereby request that the above medication, ordered by the physician/dentist for my child
________ be administered by school ______ be self-administered. I understand that I must supply the school with the
prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will
provide no more that a 45 school day supply of 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.

Name: __________________________ Relationship to child: __________________

Signature: __________________________ Telephone: __________________

Address: __________________________