

FRANKLIN ELEMENTARY SCHOOL
206 Pond Road
North Franklin, CT 06254
(860) 642-7063

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
FES School Nurse

Bob Austin
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 _____
(Type or Print)

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 than 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: _____