

Below you will find the medication policy for the Region #10 School System. Please make yourself aware of the district policy and complete the following form for all medication(s) other than Acetaminophen (Tylenol) or Tums and Roloids. These were authorized on the medical release form.

REGIONAL SCHOOL DISTRICT #10 MEDICATION POLICY

Connecticut State Law and Regulations require a physician's written order and parent or guardian's authorization for a nurse to administer medications or, in his/her absence, the principal or teacher to administer medications. Medications must be in a pharmacy prepared container, which is brought to school by a person over 18 years of age and left in school for the duration of the medication. It must be labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and date of original prescription physician's or dentist's order.

The form on the reverse side of this policy should be filled out: top half by the physician or dentist ordering and the bottom half by the parent or guardian.

Any medication ordered three time a day, twice a day or once a day is given at home unless specifically needed and told by the ordering physician.

When a prescription is taken to the pharmacy and medication is needed for school, let the pharmacist know that you need a school container as well as a container for home. The pharmacist will see that this need is met for the school.

All medication coming into the school is brought in by an adult or guardian, 18 years of age or older and must be picked up by an adult as well. Children are not allowed to transport or have medication in their possession.

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**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL
PUBLIC ACT NO. 723 OF 1969**

The Connecticut State Law and Regulations requires a physician's written order and parent or guardian's authorization for a nurse to administer medicinal preparations exclusive of hallucinogens or narcotics or, in his/her absence, the principal or teacher to administer oral medications.

PHYSICIAN'S ORDER

Name of Child: _____ Date: _____

Address: _____ Date of Birth: _____

Condition for which drug is being administered: _____

Name of Drug: _____

Amount of Drug: _____

Time of administration: _____

Relevant side effects to be observed, if any: _____

Other Suggestions: _____

Length of time during which medication shall be administered:

From: _____ To: _____

Signature: _____ M.D.

Address: _____

Telephone: _____

Student May Self Carry
(please check one)

Yes _____

No _____

**AUTHORIZATION OF A PARENT OR GUARDIAN CONCERNING THE ADMINISTRATION OF ABOVE
MEDICINES BY SCHOOL PERSONNEL**

To: _____

Date: _____

I hereby request that school personnel give my child _____
The medication ordered above by his/her physician

Signature: _____

Address: _____

Town/City: _____

Telephone: _____