TOWN OF MANCHESTER AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY PERSONNEL

Connecticut State law requires a written order from a licensed physician or dentist along with a permission form from a parent/guardian in order for school/camp personnel to be able to administer over the counter and prescription medication to a student. For the safety of all concerned, medication to be administered through the school/camp be delivered to the school/camp nurse by a parent, guardian or a designated responsible adult, and be in the original, labeled container that it was dispensed or purchased in. In the absence of the school nurse, the principal, or teacher will administer the medication or; at a camp program, Discovery Camp staff or Manchester Park and Recreation staff, will administer the medication.

PHYSICIAN OR DENTIST'S ORDER

Name of Child	Date
Address	Date of Birth
Condition for which drug is being administered during school h	nours
DRUG: Name, dose and frequency of administration	
Time of administration	
Medication shall be administered from	
Relevant side effects to be observed, if any	(Date)
If there are side effects, plan for management	
Is this a controlled drug? Yes No	If yes, DEA number
This student has been evaluated and is deemed to be capable of	
Physician/Dentist's Name	Telephone
Address	
Physician's or Dentist's Signature	Date
Nurse/Principal/Teacher/Camp Staff	Date
SCHOOL/CAMP PERSONNEL: To School/Camp Personnel: I hereby request that the above medication, ordered by an author by school/camp personnel only. I understand that I must supply dispensed and properly labeled, with student and prescriber's n dentist's name and date of original prescription. I will provide	administration of the above medication by orized prescriber be administered to my child,
I give my consent for verbal and/or written communication bet treatment/medication related purposes.	ween my child's health care provider and the school/camp nurse for
SPECIAL INSTRUCTIONS FOR STUDENTS TAKING Method the numbered situations: 1. Late Arrival: give meds upon arrival at school	TEDICATION AT SCHOOL : Please check the appropriate box for each of omit dose(s)
2. Early Closing: give meds as scheduled	omit dose(s)
3. Field Trips:	omit dose(s)
4. Self Medication: I give permission for my child to sel	f medicate, and have reviewed the requirements with the school/camp nurse
Name:	Relationship to Child:
Signature:	Address:

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