

**COVENTRY PUBLIC SCHOOLS**  
**Authorization for the Administration**  
**Of Medicine by School Personnel**  
For Coventry Preschool Program

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 written authorization of a parent/guardian for a school nurse, or in the absence of the nurse, a designated principal or teacher to administer medication.

*Note: medications must be brought to and from the school by a parent/guardian or other responsible adult. All medications must be in the original pharmacy or commercially labeled container.*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_

Condition for which Medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time of Administration: \_\_\_\_\_ Is this a controlled drug?  NO  YES

Relevant side effects:  none expected  yes (specify): \_\_\_\_\_

ALLERGIES:  NO  YES (specify): \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
(month/day/year) (month/day/year)

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_



---

**PARENT/GUARDIAN AUTHORIZATION**

I here by request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone#: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone#: \_\_\_\_\_

*\*This medication will be sent on fieldtrips and given on early dismissal days unless otherwise specified.*

