Norwalk City Schools

Medication Administration Forms:

Epinephrine Auto-injector

Asthma Inhaler

Parent Authorization for Rx

Parent Authorization for Non-Prescription Drug

Release: September 10, 2010

Norwalk City Schools

AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Student Name:_____ Date: _____

Address:_____

Name of Medication in Autoinjector: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Prescriber must acknowledge one of the following (please initial):

The student is capable of possessing and using the autoinjector: Yes_____ No_____

The student has been trained on the proper use of the autoinjector: Yes_____ No_____

The autoinjector should be used in the following circumstances: _____

_____

_____

Procedure to follow if student is unable to administer the anaphylaxis medication: _____

_____

_____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis:_____

_____

_____

Adverse reactions that should be reported to the prescriber: _____

_____

_____

Adverse reactions for unauthorized user:_____

_____

Other special instructions: _____

_____

_____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber Name:_____Phone: _____

Signature:_____Date: _____

Parent/Guardian Name:_____ Phone: (Home) _____

(Work) _____

(Other) _____

Signature:_____Date: _____

Other Emergency Contact Name:_____Phone: _____

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

- The principal or school nurse (if one has been assigned to the student's building) has been provided with a backup dose of the student's medication: Yes_____ No_____
- Principal or school nurse must acknowledge one of the following (please initial):

  I have received a backup dose of the student's medication: Yes_____No _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.

Norwalk City Schools

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s).

Medication: _____

Dosage: _____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is anychange in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-non-prescribed medication(s) or treatment(s):

_____

_____

_____
Principal

09-2010

Norwalk City Schools

PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED MEDICATION / DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
_____ Signature of Parent*
Date

_____ _____
Home Telephone Work Telephone

*Parent, guardian, or other person having care or charge of the student.

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug) _____
_____
_____

Date the administration of the drug is to begin_____

Date the administration of the drug is to cease_____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered _____
_____
_____

Specify any special instructions for administration of the drug, including sterile conditions and storage
_____
_____
_____

Report the following side effects (i.e., severe adverse reactions) to my office immediately _____
_____
_____
_____
_____
_____

Prescriber's Signature_____ Telephone _____

Printed/Typed Name_____ Date_____

Norwalk City Schools

AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER/OTHER EMERGENCY MEDICATION(S)

Student Name:_____ Date: _____

Address:_____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.

[ ] keep emergency medication in his/her possession.

[ ] self-administer the prescribed medication as permitted by law.

Medication Name:_____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease:_____

Adverse reactions that should be reported to the prescriber:_____

_____

Adverse reactions for unauthorized user:_____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication:_____

_____

_____

Other special instructions: _____

_____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name:_____Phone:_____

Signature:_____Date:_____

Parent/guardian name:_____Phone: (Home) _____

(Work) _____

(Other) _____

Signature:_____Date:_____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.
09-2010