Nurses Office
New Milford High School
388 Danbury Road
New Milford, Connecticut 06776
Telephone: 860-350-6647 Ext 1164 or 1165
Fax: 860-210-2258
Lynn D. Holmes, R.N. Ext 1164
Linda Westlake, R.N. Ext 1165

March 1, 2016

Dear Parents/Guardians:

If your child **requires** medication, prescription or over the counter, while attending the band trip, please follow the procedures required by New Milford Public Schools and State of Connecticut Please see the back of the "AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL" form.

Medication and paperwork (medication form completed and signed by prescriber and parent/guardian) are to be in the nurses office by **FRIDAY, APRIL 8th.**

Medications are to be brought in to the nurses' office by a responsible adult.
Send the amount of medication needed for the trip ONLY.

Thank you for your cooperation. Please contact the school nurse if you have questions.

Sincerely,

Linda Westlake RN NMHS Nurse Ext 1165

Lynn Holmes RN NMHS Nurse Ext 1164

New Milford Public Schools

Procedure for Requesting Medication Administration

If your child requires a prescription or over the counter medication during the school day, you must follow the procedures required by New Milford Public Schools, Connecticut General Statutes, Sec. 10-212a and Connecticut Administrative Regulations, Sec. 10-212a-1 through 10-212a-7. These procedures promote safe practices for students and staff. Please read them carefully.

1. Prescribed medication will be administered during school hours, only if it is not possible to achieve the desired effect by home administration. For each medication that must be administered daily or on an as-needed basis, the parent must obtain the written order of an authorized prescriber (physician, dentist, advanced practice registered nurse, physician assistant or optometrist) using New Milford Public Schools' form, "Authorization for the Administration of Medicine by School Personnel."
   A new order is required each school year.

2. The authorized prescriber must fill in the information requested on the form:
   a) Name and strength of the medication;
   b) Reason that the medication must be given (diagnosis):
   c) Amount (dosage) of medication to be administered and route of administration;
   d) Potential side effects of the medication;
   e) Time of day that the medication is to be administered; and
   f) Duration of the order to administer the prescribed medication.
   g) If applicable, authorization for self-administration in school

3. A parent or guardian must sign the "Parent/Guardian Authorization" portion of the form and, if applicable, provide authorization for self administration in school.

4. The medication must be packaged in the **ORIGINAL PHARMACY CONTAINER**, clearly labeled with the student's name, the authorized prescriber's name, and the prescription

5. The medication and completed authorization form must be delivered to the school nurse by a responsible adult.

6. Students may self administer inhalers, cartridge injectors for medically diagnosed allergies, and maintenance medication for diabetes provided that required written documentation is provided.

7. Self administration or carrying over the counter medication is not permitted in New Milford Public Schools.

8. Self administration of controlled medication is not permitted.

9. **No more than a (3) three month supply may be stored at school.**

10. At the end of the school year, **any unused medication will be destroyed if it is not picked up by a responsible adult by the end of the last day of school.**

It may be helpful to take the attached authorization form with you to your healthcare provider to have available for documentation if medication is prescribed for your child.

Thank you for your cooperation. Please contact the school nurse if you have any questions. 2/13 LH

New Milford Public Schools **School:** _____ **Grade:** _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

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 parent/guardian written authorization, for the nurse, or in the absence of the nurse, a designated principal or teacher to administer medication. Medications must be in the original properly labeled container and dispensed by a physician or pharmacist.

PRESCRIBER'S AUTHORIZATION

Name of Student: _____ Date of Birth: _____

Address: _____ City/Town: _____

Condition for which drug is being administered: _____

Drug Name : _____Generic name_____Dose:___ _____Route: _____

Time of Administration: _____ if PRN, frequency _____

Relevant side effects [ ] None expected [ ] Specify: _____

ALLERGIES [ ] NO [ ] YES (Specify): _____

Medication shall be administered from _____ to _____
(up to 12 months) Month/Day/Year Month/Day/Year

Prescriber's Name/Title _____
(Type or print)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

Use for Prescriber's Stamp

PARENT GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a three month 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.
I grant permission for the school nurse to exchange information with this prescriber regarding the administration of this medication.

Parent/Guardian Signature: _____ Date: _____

Parent's Home Phone #: _____ Work # _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

*Self-administration of a medication **may** be authorized by the prescriber and parent/guardian for **certain** medications and **must** be approved by the school nurse in accordance with Board policy and district nursing protocols.*

Prescriber's authorization for self-administration [ ] Yes [ ] No _____
(Signature) (Date)

Parent/Guardian authorization for self administration: [ ] Yes [ ] No _____
(Signature) (Date)

School nurse approval for self administration: [ ] Yes [ ] No _____
Received by:_____ Date Med Authorization received_____Date Medication received_____