Medical Forms Required

- All students requiring any medication during the school day or for after school activities must have an Authorization for Administration of Medicine Form completed and signed by your health care provider and the parent/guardian. **Over the counter** medication must be delivered to school in its original, unopened container. **Prescription medicines** must be delivered in their original pharmacy container with the prescription label. All medications must be brought into school by an adult over 18 years old, NOT the student. The only medications that students may carry & self-administer are asthma inhalers, Epi-pens and diabetic medications. A medication authorization form must be given to the nurse in order to carry these medications. The nurse will be at school 3 days prior to the student's first day. You may deliver your child's medication any time prior to the opening of school and during school hours.

Sports Physical Exam

- If you child is interested in playing ANY sport during the school year, your health care provider must clear them to participate fully in athletic activities and competitive sports as part of their physical exam. Students must have a valid history, signed permission and a physical on file with the SCHOOL NURSE (not coach) in order to try-out, practice or play a sport.
- Physical exams are valid for 13 months from the date of the exam. If you have questions about this exam, do not have insurance or have other circumstances that make it difficult for your child to obtain this exam, please call the School Nurse. The School Based Health Clinic may perform this exam with a signed enrollment form. Forms are available at school or you may call them directly at 860-822-4909.

Diabetic Students

- If your child has diabetes, please contact the School Nurse if you have not received your child's diabetic packet mailed home in early June.

Activity Restrictions/Orthopedic Appliances

- If your child will need any special accommodations in the classroom or trade area or if your child will be entering school with any orthopedic appliances such as crutches, arm, leg braces, etc. Please have you health care provider complete and sign the Activity Restrictions Form found on our website under School Nurse and then forms. You may also pick the form up at school.

Visits outside the United States

- If your child has visited a location outside the United States for more than one week, please notify the School Nurse. You child may require a tuberculin skin test prior to returning to School.

Please contact Jennifer L. Briggs RN School Nurse: 860-887-8453/jennifer.briggs@ct.gov

Connecticut Technical High School System

School: _____ **Grade** _____ **Shop:** _____ **Date Received:** _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Ct 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 permission from the parent/guardian for the nurse, or in the absence of the nurse, a trained staff member to administer medication. **All non-prescription medications must be in their original, unopened container labeled with the student's name. All prescription medications must be in the original pharmacy labeled container. An adult must bring controlled medications** (Ritalin, Concerta, etc.) **to the school.**

PRESCRIBER'S AUTHORIZATION

Name of Student_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Condition for which medication is being administered_____.

Name of Medication: _____ Dose: _____ Route_____

Schedule for Administration: _____. ☐ PRN for: _____.

Side Effects: ☐ None expected ☐ Specify_____. Administer from: _____ to _____.
Month/Day/Year Month/Day/Year

Allergies: ☐ None ☐ Yes (specify): _____

Order for field trips: ☐ Give medication ☐ Omit medication. **Order for Production:** ☐ Give medication ☐ Omit medication. **Student has prescriber's permission to carry and self-administer:** ☐ Epi-Pen ☐ Inhaler ☐ Diabetic Medications

Prescriber's Signature_____ **Date:**_____

Name/Title_____

Address_____

Phone_____ Fax_____

Prescriber's Stamp

☐ ***A verbal order for the above medication was taken on*** _____

from_____ ***by***_____ ***RN, School Nurse***

PARENT/GUARDIAN AUTHORIZATION

I authorize the School Nurse or other medication administration trained school personnel to administer the medication ordered above. I understand that I must supply the school with no more than a 45 day supply of the medication and that the medication will be destroyed if not picked up within one week of being discontinued, or the last day of school, whichever comes first. I authorize the School Nurse to communicate with the prescriber regarding treatment for the condition noted above.

☐ **I give permission for my child to carry and self-administer the above, if authorized by prescriber and School Nurse.**

Parent/Guardian's Signature: _____ Date: _____

Phone Numbers: _____ **(home#)** _____ **(work#)** _____ **(cell #)**

☐ Medication order was reviewed by School Nurse.
☐ Self-administration was reviewed, evaluated and approved by the School Nurse in accordance with CTHSS policy.

School Nurse's Signature: _____, RN **Date:** _____

MB 1/08

Norwich Technical High School ■ 7 Mahan Drive ■ Norwich, CT ■ 06360 ■ Phone: (860) 892-2149 ■ Fax (860) 823-1567