Meliora Academy, Inc.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Student Name:			Date of Birth
Street Address:			
Allergies:			
Condition for which medication is prescribed:			
Medication Name:	Dose:		Route:
Time of Administration:			Frequency:
Medication Administered Date:	From:		To:
Relevant side effects:			
Prescriber Name and Title: (print)			
Prescriber Signature:			Date:
Prescriber Phone:	Fax		
Prescriber Address:			

Staff trained in medication administration will administer medications according to the written order by a licensed physician, advanced practice nurse, physician's assistant or dentist above. I give permission for Meliora Academy School Nurse/ qualified staff to administer medication to my child in accordance with *Connecticut State Law and Regulations Section 10-212a and the written orders above.

Parent/Guardian Signature:	Parent/Guardian Print Name:	Date:
Home # :	Cell #:	Work #:

*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), parent/guardian written authorization, and permission for the nurse to communicate with the prescriber, 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/pharmacist.