ST.VINCENT'S SPECIAL NEEDS SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

NAME OF STUDENT: ____ **DOB**_____________________________

Dear Parents/Guardians:
The following medications are available for your child at school. They have been approved by our Medical Advisor.

The Connecticut State Law and Regulations 10-121(a) require a written 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 medications.

PLEASE PUT YOUR 1: INITIALS NEXT TO THE MEDICATION YOU WOULD LIKE GIVEN
2: CIRCLE THE DOSE
3: AND SIGN WHERE INDICATED BELOW

- **TYLENOL** (Acetaminophen 160mg/5 ml) **INITIALS**_______
- **MOTRIN** (Ibuprophen 100mg/5 ml) **INITIALS** _______

Tylenol/Motrin to be given for fever greater than 101.0 or for discomfort x1 while in school

Doses:

24-35 lbs	5 ml
36-47	7.5 ml
48-59	10 ml
60-71	12.5 ml
72-95	15 ml
over 95	20 ml

- **BENADRYL** **INITIALS**_______

For allergic reaction x1 while in school
(Diphenhydramine Hcl 12.5mg/5 ml)

Doses:

26-32 lb	5 ml
33-43	7.5 ml
44-54	10 ml
55-65	12.5 ml
66-88	15 ml
over 88	20 ml

Tylenol, Motrin, and Benadryl will be given orally or via G or J tube as indicated.

- **BACITRACIN** Topical **INITIALS**_______
  Apply to wound x1 while in school
- **DIAPER RASH CREAM** Topical **INITIALS** ______
  Apply to perineal area as needed for rash with each diaper change (Desitin/Balmex/Zinc etc.)
- **NURSE may replace MIC-KEY button if needed during school.** **INITIALS**_______

Length of time which medication can be administered: **FROM: 9/5/23 TO: 8/30/24**

PHYSICIAN'S NAME: ____

PHYSICIAN'S SIGNATURE: ____

I hereby request that the above medications be administered by school personnel.

SIGNATURE OF PARENT/GUARDIAN____ **DATE**_________________________

Prn Tylenol Form KK/cs