AUTHORIZATION/PARENTAL CONSENT FOR SCHOOL TO PROVIDE MEDICATION OR STUDENT TO SELF-ADMINISTER MEDICATION

NOTE: Use a separate authorization form for each medication. Provide the school with a new form each school year, each time the student has a new medication, when the District assigns a new medication provider to the student, and each time there is a change in the student's current medication regimen.

Student's last name: _____

Student's first name: _____

Gender: _____ Grade: _____

Date of birth: _____/_____/_____

NOTE: Attach a copy of a current photo of the student. This will be used to properly identify the student before providing medication.

EMERGENCY CONTACT INFORMATION

Parent/guardian's emergency contact name and number: _____
_____ ☐ Home ☐Work ☐Cell

Parent/guardian's emergency email address:

_____

Alternate family member's emergency contact name and number: _____
_____ ☐ Home ☐Work ☐Cell

Relationship to student: _____

Primary healthcare provider's name and phone number:

_____

Secondary healthcare provider's name and phone number (if applicable):

_____

Student's pharmacy name and phone number: _____

STUDENT HEALTH INFORMATION

Does the student have any known allergies? ☐ Yes ☐ No

If yes, attach a list of known allergies to this form and certification from a healthcare provider that the student is not known to be allergic to any medication the school is requested to provide or any medication that the student will self-administer.

The student has knowledge of his/her known allergies and has been educated on the signs and symptoms of allergic reactions and how to prevent them.

☐ Yes ☐ No

Will the student be taking more than one medication at school or while otherwise under the school's supervision? ☐ Yes ☐ No

If yes, attach certification from a healthcare provider that the medications are not known to adversely interact or information on how to avoid any known adverse interactions.

MEDICATION AUTHORIZATION

*NOTE: Fields marked with an * must be completed by a healthcare provider for prescription medication.*

*Medication's name: _____

*Relevant diagnosis: _____

Dates medication must be provided at school:

☐ Short term, list dates to be given: _____

☐ Every day at school until:

☐Medication is gone ☐End of the school year ☐Other:_____

☐ Episodic/Emergency Events ONLY (explain): _____

_____

_____

*Dosage (amount) _____ *Route _____ *Form _____

NOTE: Requests to provide more than the recommended dosage for over-the-counter medications must be accompanied by a healthcare provider's authorization.

Time(s) of day*: _____

_____

NOTE: If request is to provide medication after school hours when the student is under district supervision, the parent/guardian must work with the building administrator to develop a plan for coordinating this request.

*Serious reactions/adverse side effects from this medication may occur:

☐Yes ☐ No

*If yes, describe:_____

_____

_____

*Action/treatment for reactions:

_____

*Special handling instructions: ☐Refrigeration ☐Keep out of sunlight

☐Other: _____

*Is any dispensing equipment or other medical equipment required in order for the student to receive medication?

☐Yes ☐ No

*If yes, describe equipment and any special storage instructions: _____

_____

_____

STUDENT SELF-ADMINISTRATION

*NOTE: Fields marked with an * must be completed by a healthcare provider for prescription medication.*

*This student has received instruction in self-administering this medication in a secure manner. In addition, the student has received education on any side effects or adverse interactions associated with the medication and how to prevent them: ☐ Yes ☐ No

*The student is capable of self-administering this medication in a secure manner.

☐ No ☐Yes--Supervised ☐ Yes--Unsupervised

This student may carry this medication: ☐No ☐Yes

HEALTHCARE PROVIDER'S AUTHORIZATION

NOTE: This consent is only required for:

A. Prescription medication

B. Over-the-counter medication if it is to be provided in a manner inconsistent with manufacturer's recommendation.

*I certify that the information contained on this form is accurate and complete to the best of my knowledge.

_____

Healthcare provider's name (print)

_____ _____

Healthcare provider's signature Date

CONFIDENTIALITY WAIVER

NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA).

I _____ (parent/guardian's name) authorize (name of agency and/or health care providers): _____to provide health information from _____(student's name) medical record to: Richland #44 School District.

The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.

Requested information shall be limited to the following: ☐All minimum necessary health information; or ☐ Disease/condition-specific information as described:

_____

This authorization shall become effective immediately and shall remain in effect until ____ (enter date) or for the remainder of the school year from the date of signature (if no date entered).

Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____

Parent/guardian's signature Date

NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider upon completion.