



Over-the-Counter Medication Request and Authorization for Medication Administration

Student Name: _____ Grade: _____ DOB _____ / _____ / _____

Address: _____ Phone: _____

Parent: _____ Doctor: _____

PARENT REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

I request and authorize designated school personnel to give the medication listed below to my child. The medication(s) is/are to be furnished by me. I release school personnel from any liability should reaction(s) result from the medication. I understand that pertinent information will be shared with appropriate school staff.

Medication to be taken at school:

<u>Name of Medication</u>	<u>Dose</u>	<u>Time to be given</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Functional restrictions or side effects from medication: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is 1 year, to include summer school, if applicable.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising or inspection of medical records.

X _____

Signature of patient, parent of minor, or personal representative

Relationship

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION