Request and Authorization for Self-Carry/Self-Administration

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

Address: _____ Phone: _____

Parent: _____ Doctor: _____

PARENT REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

I request and authorize my child to be responsible for his/her own medication on his/her own person and self-administer medication also, thereby releasing school personnel from liability should inappropriate usage and/or reactions result from the medication(s). I give my permission for the school nurse to contact my physician/dentist/nurse practitioner regarding this medication. I understand that pertinent information will be shared with appropriate school staff.

Medication to be taken at school:

Name of Medication	Dose	Time to be given
_____	_____	_____
_____	_____	_____
_____	_____	_____

Functional restrictions or side effects from medication: _____

I herby authorize _____
(name and address of releasing facility)

To release information to
_____
(individual name, facility/organization and address)

Information to be released:

Medication orders for the administration of medication during the school day.

_____ _____
Physician's Signature ***Date***

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