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. I release school personnel from any liability should reaction(s) result from the medication. 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