

PARENT REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

Student Name: _____ Birthdate: _____

Address: _____ Phone: _____

School: _____ Grade: _____ Parent(s): _____

Medical Diagnosis: _____

I request and authorize designated school personnel to give the medication listed below to my child. I release school personnel from any liability should reactions result from the medication. I give my permission for the School Nurse to contact my physician / dentist 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 hereby 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 redisclosure 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 Statue 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising 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