Independent School District No. 709
Duluth, Minnesota

AUTHORIZATION TO ADMINISTER MEDICATION

Student Name: _____ Birthdate: _____

Address: _____ Phone: _____

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

Medical Diagnosis: _____

PARENT'S 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 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 hereby authorize release of information between _____
(name and facility/organization name)

And _____
(name and facility/organization name)

Information to be released:

1. Medication orders for the administration of medication during the school day
2. Health information related to medical orders.

_____ _____
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