Authorization/Parental Consent For School To Provide Medication Or Student To Self-Administer Medication

Note: **Use a separate authorization form for each medication.** Provide the school with a new form each school year, each time the student has a new medication, when the District assigns a new medication provider to the student, and each time there is a change in the student's current medication regimen.

Student's Name: (first) _____ (last)_____

Gender: ☐ F ☐ M Grade:_____ Date of Birth: _____/_____/_____

Emergency Contact Information

Parent/Guardian Name:_____ Relationship:_____ Phone:_____

Parent/Guardian Name:_____ Relationship:_____ Phone:_____

Primary Healthcare Provider Name:_____ Phone:_____

Secondary Healthcare Provider Name:_____ Phone:_____

Pharmacy Name:_____ Phone:_____

***Completed by Healthcare Provider for prescription medication or parent/guardian for over-the-counter medication**

Student Health Information

Does the student have any known allergies? ☐ Yes ☐ No

If yes, healthcare provider attach a list of known allergies to this form and certification that the student is not known to be allergic to any medication the school is requested to provide or any medication that the student will self-administer.

The student has knowledge of his/her known allergies and has been educated on the signs and symptoms of allergic reactions and how to prevent them. ☐ Yes ☐ No

Will the student be taking more than one medication at school or while otherwise under the school's supervision? ☐ Yes ☐ No

If yes, healthcare provider attach certification that the medications are not known to adversely interact or information on how to avoid any known adverse interactions.

Medication Authorization

Medication's Name:_____ Relevant Diagnosis:_____

Dates Medication must be provided at school:

☐ Short term, list dates to be given:_____ ☐ Episodic/Emergency events ONLY

☐ Every day at school until: ☐ Medication is gone ☐ End of school year ☐ Other:_____

Dosage (amount)_____ Route_____ Form_____

Note: Requests to provide more than the recommended dose for over-the-counter medications must be accompanied by a healthcare provider's authorization

Time(s) of day_____

Note: If request is to provide medication after school hours when the student is under district supervision, the parent/guardian must work with the building administrator to develop a plan for coordinating this request.

Serious reactions/adverse side effects from this medication may occur: ☐ Yes ☐ No

*if yes, describe:_____

*Action/treatment for reactions:_____

*Special handling instructions: ☐ Refrigeration ☐ Keep out of sunlight ☐ Other:_____

*Is any dispensing equipment or other medical equipment required in order for the student to receive medication? ☐ Yes ☐ No If yes, describe:_____

Student Self-Administration

The student is capable of self-administering this medication in a secure manner.

☐ Yes – Supervised ☐ Yes – Unsupervised ☐ No

In addition, the student has received education on any side effects or adverse interactions associated with the medication and how to prevent them: ☐ Yes ☐ No

This student may carry this medication: ☐ Yes ☐ No

Healthcare Provider's Authorization

Note: This consent is required for prescription medication and over-the-counter medication if it is to be provided in a manner inconsistent with the manufacturer's recommendation.

*I certify that the information contained on this form is accurate and complete to the best of my knowledge.

_____

Healthcare Provider's Name (print)

_____ _____

Healthcare Provider's Signature Date

***Completed by Parent/Guardian**

Confidentiality Waiver

Note: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA).

I _____ (parent/guardian's name) authorize _____ (name of agency and/or healthcare providers) to provide health information from _____ (student's name) medical record to _____ (name of school). The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.

Requested information shall be limited to the following: ☐ All minimum necessary health information; or ☐ Disease/condition specific information as described:_____

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for the remainder of the school year from the date of signature (if no date entered).

Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the education setting.

_____

Parent/Guardian's Name (print)

_____ _____

Parent/Guardian's Signature Date

Note: A copy of this confidentiality waiver must be provided to the student's healthcare provider upon completion.

Parental Consent

I am the parent or guardian of _____ (student's name). I give my permission for him/her to take the following medication while in _____ (name of school). I authorize the following individuals to provide medication to my child:

_____ (Name of Eligible school medication provider)
_____ (Name of Eligible school medication provider)
_____ (Name of Eligible school medication provider)
_____ (Name of Eligible school medication provider)

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I hereby release Divide County School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____

Parent/Guardian's Name (print)

_____ _____

Parent/Guardian's Signature Date

Student Agreement for Self-Administration

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I also acknowledge and agree to comply with the district's drug and alcohol-free school policy, which contains restrictions related to medication, including rules prohibiting me from giving medication (prescription and over-the-counter) to other students.

Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another school employee.

If I have received permission to carry medication, I agree that I will not leave the medication unattended or unsecured and accessible to other students.

_____

Student's Name (print)

_____ _____

Student's Signature Date