

EXHIBIT

ACBD-E2 - AUTHORIZATION/PARENTAL CONSENT FOR SCHOOL TO PROVIDE MEDICATION OR STUDENT TO SELF-ADMINISTER MEDICATION

*NOTE: Use a separate authorization form for each prescribed or over the counter 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 last name: _____

Student's first name: _____

Gender: _____ Grade: _____

Date of birth: ____/____/____

NOTE: Attach a copy of a current photo of the student. This will be used to properly identify the student before providing medication.

EMERGENCY CONTACT INFORMATION

Parent/guardian's emergency contact name and number: _____

_____ Home Work Cell

Parent/guardian's emergency email address:

Alternate family member's emergency contact name and number: _____

_____ Home Work Cell

Relationship to student: _____

Primary healthcare provider's name and phone number:

Secondary healthcare provider's name and phone number (if applicable):

Student's pharmacy name and phone number: _____

STUDENT HEALTH INFORMATION

Does the student have any known allergies? Yes No

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

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

MEDICATION AUTHORIZATION

*NOTE: Fields marked with an * must be completed by a healthcare provider for prescription medication.*

*Medication's name: _____

*Relevant diagnosis: _____

Dates medication must be provided at school:

Short term, list dates to be given: _____

Every day at school until:

Medication is gone End of the school year Other: _____

Episodic/Emergency Events ONLY (explain): _____

*Dosage (amount) _____ *Route _____ *Form _____

NOTE: Requests to provide more than the recommended dosage 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 equipment and any special storage instructions: _____

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STUDENT SELF-ADMINISTRATION

*NOTE: Fields marked with an * must be completed by a healthcare provider for prescription medication.*

*This student has received instruction in self-administering emergency medication in a secure manner. 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

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

No Yes--Supervised Yes--Unsupervised

This student may carry this medication: No Yes

HEALTHCARE PROVIDER'S AUTHORIZATION

NOTE: This consent is only required for:

A. *Prescription medication*

B. *Over-the-counter medication if it is to be provided in a manner inconsistent with 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

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 health care providers): _

to provide health information from _____ (student's name) medical record to: Jamestown Public Schools.

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

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is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. 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 educational setting.

Parent/guardian's signature

Date

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

PARENTAL CONSENT

I am the parent or guardian of _____. I give my permission for him/her to take the following medication while in _____ School. I authorize the following individuals to provide medication to my child:

- _____ (Eligible school medication provider)
- _____ (Eligible school medication provider)
- _____ (Eligible school medication provider)
- _____ (Eligible school medication provider)
- _____ (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 Jamestown School District and its employees from any claims, liability, or civil damages 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. NDCC: 15.1-19-16.

Parent/Guardian Signature

Date

STUDENT CONSENT

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's policy, which contains restrictions related to

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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 signature

Date

End of Jamestown Public School District Exhibit ACBD-E2