

OF
ELIZABETH BOARD EDUCATION
Elizabeth, New Jersey

AUTHORIZATION AND CONSENT TO ADMINISTER MEDICATION

Student's Name: _____ Grade: _____

Address: _____ Teacher: _____

Telephone: _____ Cell Phone: _____

I (we) request authorization and consent to have the school nurse or an appointed faculty member administer medication as prescribed by our private physician to my child while in school. I (we) also hereby release the board of education, the school physician, school nurse and all of their employees from any liability connected therewith.

Date: _____ Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Witness Signature: _____

TO BE FILLED OUT BY THE PHYSICIAN

Please administer the following medication: _____

Name of student: _____

Name of medication: _____

OF

Prescribed dosage:

Side effects that may be expected:

How long do you expect this student to be on the medication?

Comments or suggestions:

Physician's Signature:

Address: _____ Telephone Number:

APPROVAL SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse or (faculty member) to administer the prescribed medication as ordered to (Name of Student) during school hours.

Physician's Signature:

(CONFIDENTIAL NFORMATION)

ELIZABETH BOARD OF EDUCATION
Elizabeth, New Jersey

SELF-MEDICATION RELEASE FORM

I, _____ give permission for my child,

to self-medicate with _____ as prescribed by

_____ (medication)

_____ (physician 's name)

in emergency situations where the nurse or parent/guardian is not present on-site, off-site, or at an after-school activity.

- I agree to provide an identical copy of any inhaler/s, epi-pen or other auto-injector, or glucagon which will be stored in a locked cabinet in the original container in the nurse's office.
- A note from the prescribing physician is attached which includes the dosage and timing of medication and a notation of each instance of administration, as well as certification that the student is capable of self-medication and has been instructed on the proper administration of his/her medication.
- In the event that my child, _____, self-administers medication according to Board of Education policy _____ 5141.21 Administering Medication, I release the school district of any and all liability.
- I have received and reviewed the provisions of policy 5141.21 Administering Medication.

Parent/guardian signature:

Date:

_____ ELIZABETH BOARD OF EDUCATION

OF
Elizabeth, New Jersey

EMERGENCY ADMINISTRATION OF EPINEPHRINE

Dear

Parent/Guardian

The _____ Board of Education hereby informs you that if board-approved procedures are followed, the district and its employees shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorney's fees as a result of any injury arising from the emergency administration of epinephrine.

I, _____, hereby acknowledge that, if the district procedures are followed, the district shall incur no liability whatsoever for any and all claims, damages, losses and expenses of any kind, including reasonable attorney's fees as a result of any injury arising from the emergency administration of epinephrine.

I, _____, hereby indemnify and hold harmless the district and its employees, officers or agents against any and all claims arising from the emergency administration of epinephrine.

I, _____, hereby acknowledge that if epinephrine is administered to my child, district policy and procedure require that he/she receive immediate medical care following the administration of epinephrine.

I, _____, hereby further agree to assume full financial responsibility for any and all costs in connection with the medical care provided to my child, including but not limited to, transportation expenses to and from a medical facility.

Parent/Guardian

Date

Board policy and regulation: 5141.21 Administration of Epinephrine

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Patient/Student Name: _____ Date of Birth: _____

I hereby authorize _____ [insert health care provider name & title] and _____ [insert name & title of school official] to exchange health and education information/records for the purpose listed below.

_____ [insert address & telephone of school/school district]

Description:

The health information to be disclosed consists of:

The education information to be disclosed consists of:

Purpose: This information will be used for the following purpose(s):

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: _____

Authorization

This authorization is valid for one calendar year. It will expire on __[insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent Signature

Date

Student Signature*

Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form.

Copies: Parent or student*

Physician or other health care provider releasing the protected health information

School official requesting/receiving the protected health information