Authorization for the Administration of Medication/Treatment

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Student: _____ DOB: _____

School: _____ CIF: _____

Parent/Guardian Name: _____ Phone (Home/Work/Cell): (____) _____

Clinic Name: _____ Contact Person: _____

Clinic Location: _____

Phone: (_____) _____ Fax: (_____) _____

Authorization:

1. The purpose of this consent form is to authorize for the safe and necessary administration of medication and treatments in school as ordered by my health care provider in my child's *(check all that apply)*:

   ___ **Anaphylaxis Action Plan** ___ **Asthma Action Plan** ___ **Diabetes Management Plan**

   ___ **Seizure Action Plan** ___ **Other** *(Please specify name of plan)*: _____

2. As indicated in the above **Plan(s)** signed by the health care provider my child has permission to *(check all that apply)*:

   ___ **Self-Carry Medication(s)** ___ **Self-Administer Medication(s)**

3. Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
4. Information regarding this order will only be given to Saint Paul Public Schools professional staff who need this information for your child's/adolescent's safety and education.
5. The prescribing health care provider may **release information to** and/or **request information from** SPPS professional staff related to the authorized service(s).
6. SPPS professional staff may **release information to** and/or **request information from** the prescribing health care provider related to the service(s).
7. I understand that:
   - This authorization takes effect the day that I sign it and expires one year from the date of my signature.
   - I may revoke this authorization at any time by giving written notification.
   - Health records, once received by the school district, may no longer be protected by Health Insurance Portability and Accountability Act (HIPAA), but they will become education records protected by Family Educational Rights and Privacy Act (FERPA).
   - Educational records, once received by another individual or agency, may no longer be protected by FERPA, but may be protected by HIPAA.
   - This information, except as allowed by law, may not be re-disclosed without my consent.
   - A photocopy/fax or electronic copy of this authorization, which has not been altered, will be treated in the same manner as the original.

_____ _____

Signature of Parent/Guardian/Adult Student **Date**

Return to:

School Health Office at: _____

School Nurse: _____ Phone: 651-888-76____ Fax: 651-_____