AUTHORIZATION/PARENTAL CONSENT FOR SCHOOL TO PROVIDE 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, and each time there is a change in the student's current medication regimen.

Student's full name: _____

Gender: M F Grade: _____ Date of birth: ___/____/____

EMERGENCY CONTACT INFORMATION

Parent/guardian's emergency contact name: _____

Home # _____ Work # _____Cell # _____

Alternate emergency contact name and number: _____

Home # _____ Work # _____Cell # _____

Primary healthcare provider's name and phone number:

_____

Name of medication _____

Dose: _____ Route: _____

Frequency: _____ Continue until: _____

Special Instructions: _____

Possible side effects on learning or physical function: _____

_____

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

If yes, list known allergies: _____

CONFIDENTIALITY WAIVER and PARENTAL CONSENT

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 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.

Signing this authorization is required in order for my child to obtain medication services in the educational setting.

I give my permission for _____ (child's name) to take medication while in Hazen Elementary or Hazen Junior/Senior High School. I authorize any of Hazen School District's eligible medication provider to administer medication to my child.
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 certify that medications I have authorized the school to provide my child do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I understand and hereby release Hazen 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 Signature Date

_____

Name of Parent/Guardian (please print)