AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

NOTE: Use a separate authorization form for each medication. Provide the school with a new form each school year and each time there is a change in the student's current medication regimen.

Date: _____

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

Contact Information

Parent/Guardian's Name: _____

Parent/Guardian's Phone: _____ ☐ Home

_____ ☐ Cell/Work

Emergency Contact: Name: _____

Phone: _____

Relationship to Student: _____

Physician: _____

Physician's Phone: _____

Student Health Information

Known Allergies: _____

_____

Medication Name & Prescription Number: _____

_____

Dose: _____ How Administered: _____

Times: _____

Start Date: _____ End Date (If Known): _____

M ____ T ____ W ___ Th ___ F ____ / As Needed: ☐ Yes ☐ No

Special Instructions (e.g.: Refrigeration): _____

_____

Potential Side Effects: _____

_____

Treatment in Case of Reaction: _____

_____

Will the child be taking more than one medication at a time? ☐ Yes ☐ No

Student Self-Administration/Emergency Medication

- This is an emergency medication defined as a prescription drug delivered by inhalation to alleviate asthmatic symptoms and an epinephrine auto injectable pen: ☐ Yes ☐ No
- My child may self-administer this medication: ☐ Yes ☐ No
  If Yes, then the following must also be answered:
- This student has received instruction in self-administering this 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 many carry this medication: ☐ Yes ☐ No
- Doctor's note has been submitted: ☐ Yes ☐ No

All medications must be delivered to the school in the original packaging. If dosage will be different than on original packaging, then the parent/guardian must submit permission to give a different dosage signed by the student's physician. That documentation must be attached to this form.

The Midway School District reserves the right to refuse to dispense any medications when a parent/guardian asks the school to dispense medications in an unsafe manner or in a manner that is not consistent with the instructions on the package without documentation from a physician.

The District also reserves the right to contact a medical professional if there is suspicion that the instructions provided by a parent/guardian are not accurate. Confidentiality will be preserved in such instances.

Parental Consent

As parent/guardian of the student named on this form, I give my permission for him/her to take the listed medication while in Midway Public School. I authorize the following individuals to provide medication to my child:

- Kristi Armbrust (Eligible school medication provider)
- Amanda Bina (Eligible school medication provider)
- Betty Bina (Eligible school medication provider)
- Diane Muir (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 Midway 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.

Signature _____ Date _____

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: Midway Public School District.

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.

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 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.

_____ _____

Parent/Guardian's Signature Date

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