Authorization for the Administration of Medication for Non-Public Schools

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Student: _____ DOB: _____ Male Female

School: _____ CIF: _____

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

Address: _____

To Be Completed By Practitioner Licensed To Prescribe

Clinic Name: _____ Licensed Practitioner: _____

Complete Address: _____

Phone: (____) _____ Fax: (____) _____ Effective date: _____

Medication/Treatment: _____

Dosage Route Frequency

Diagnosis: _____ ICD-9 #: _____

Discontinuation date: _____

_____ _____

Signature of Practitioner Licensed to Prescribe Date

Authorization:

1. Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
2. 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.
3. The prescribing Health Care Provider (HCP) may **release information to** and/or **request information from** SPPS professional staff related to the authorized service(s).
4. SPPS professional staff may **release information to** and/or **request information from** the prescribing HCP related to the service(s).
5. 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 *(Parental or eligible student, if over 18)*.
   - 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 Daytime Phone Date

Return to:

School Health Office at: _____

School Nurse: _____ Phone: 651- _____ Fax: 651- _____