SCOTIA-GLENVILLE CENTRAL SCHOOL DISTRICT
Scotia, New York 12302

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

PART A *- FOR PARENT OR GUARDIAN*

I request that my child _____ (dob _____) receive
(name of student)
medication as prescribed by his/her medical provider _____ .
(name of prescribing practitioner)
I give permission for the school nurse to contact the prescribing practitioner to clarify any orders that are unclear or incomplete. ***(See reverse for release of information authorization.)***

_____ _____
(signature of parent/guardian) (date)

PART B *- FOR PHYSICIAN*

In the space provided below, please **attach written authorization** for medication, signed by the prescribing practitioner, that the above named student must take while in school. Please include **medication name, dosage, frequency and route of administration**. This authorization should be written on letterhead or prescription stationery and should include the printed address and telephone number of the prescribing practitioner.

NOTE: Parents are responsible for returning this form to the school nurse.
Medication will **not** be given without this authorization.

AUTHORIZATION FOR THE EXCHANGE OF PROTECTED HEALTH INFORMATION CONCERNING AN INDIVIDUAL WHO IS A STUDENT IN THE DISTRICT

NAME OF STUDENT: _____ DATE OF BIRTH: __/__/__

NAME OF PARENT/PERSONAL REPRESENTATIVE: _____

[If not parent, please include an explanation of the basis for your claim to serve as personal representative for this student]

NAME OF HEALTH CARE PROVIDER: _____

HEALTH CARE PROVIDER ADDRESS: _____

DURATION OF AUTHORIZATION:

❒ This authorization shall remain in effect so long as the Student identified above is enrolled in schools of the Scotia-Glenville Central School District, or in a non-public school to which the Scotia-Glenville Central School District provides health and welfare services pursuant to NYS Education Law §912.

❒ This authorization expires _____

The undersigned, as Personal Representative for the Student identified above, hereby authorizes the exchange of Protected Health Information concerning the Student identified above between personnel of the Scotia-Glenville Central School District and the Health Care Provider identified above.

The Health Care Provider and the Scotia-Glenville Central School District is authorized to release:

❒ Any and all Protected Health Information in the possession of the Health Care Provider concerning the Student *(except* psychotherapy notes, if any).

❒ Only the following types of information concerning the Student:

_____

_____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that I may refuse to sign this authorization, but that my refusal to authorize release of information may affect the Scotia-Glenville Central School District's ability to provide health and welfare and other services to the student identified above.
3. I understand that I may revoke this authorization in writing at any time by delivering the written revocation to the Health Care Provider identified above, with a copy to the Scotia-Glenville Central School District. I also understand that such revocation will not be effective with respect to a disclosure of Protected Health Information the Health Care Provider or the Scotia-Glenville Central School District has made in reliance on this authorization prior to receipt of the revocation.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the Scotia-Glenville Central School District, but only in compliance with the requirements of the Family Educational Rights and Privacy Act.

Signed _____, as parent/personal representative of _____

Dated: _____