BROOKLYN CENTER community schools

Brooklyn Center Community Schools
District 286
Health Services Department

Authorization for the Administration of Medication/Treatment

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Student: _____ **DOB:** _____ *(circle)* **Male / Female**

School: _____ **Grade:** _____

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*** ***Additional Instruction***

_____

Adverse Side Effects

Diagnosis: _____ **ICD-10 #:** _____

Medication/Treatment Discontinued 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 Brooklyn Center Community 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 BCCS professional staff related to the authorized service(s).
4. BCCS professional staff may **release information to** and/or **request information from t**he 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 (HIPPA) but they will become education records protected by Family Educational Right 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 is 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 **Date**

Return to:

School Health Office at: **Earle Brown Elementary**
1500 59th Ave N, Brooklyn Center, MN 55430

School Nurse: ***Tina Spanier,***
RN, Licensed School Nurse
Phone: **(763) 561-4480 Ext: 4020**
Fax: **(763) 560-1674**