BROOKLYN CENTER MIDDLE & HIGH SCHOOL
SCIENCE. TECHNOLOGY. ENGINEERING. ARTS. MATH.

6500 Humboldt Ave N,
Brooklyn Center, MN 55430
763 561 2120

Authorization for the Administration ofMedication/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: _____

Clinic Name: _____ **Licensed Practitioner:** _____

Address: _____
Phone: (_____)_____ **Fax:** (_____)_____

To Be Completed by Practitioner Licensed to Prescribe

Medication/Treatment: _____

_____

Dosage ***Route*** ***Frequency*** ***Additional Instruction***

_____

Adverse Side Effects

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

Medication/Treatment Discontinued Date: _____

_____ _____

Signature of Practitioner Licensed to Prescribe ***Date***

Parent/Guardian Authorization:

1. I request that the above medication be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication be given on field trips as prescribed.
2. I will notify the school of any change in the medication, (i.e., dosage change, medication is stopped, etc.).
3. I give permission for the medication to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.
6. Medication must be supplied in original/prescription bottle.
7. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication.
8. I give permission for the school nurse to consult with my student's physician/licensed prescriber about any questions regarding the listed medication or medical condition being treated by the medication.
9. I give permission for the physician/licensed prescriber to release information related to the above medication and medical condition to the licensed school nurse.

* _____

Signature of Parent/Guardian **Date**

Return to : Brooklyn Center School -District 286
Deb Erickson, Licensed School Nurse
Phone: 763-561-2120 Ext. 3203 FAX: 763-450-3477