# AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION/TREATMENT
## HIPAA-Compliant Authorization for Exchange of Health & Education Information

Student: _____ CIF: _____ DOB: _____ School Year: _____

Procedure for Medications/Treatments at School:

- Medications/treatments required must be administered or delegated by the Licensed School Nurse (LSN).
- Medication must be brought to school in a container appropriately labeled by a pharmacist.
- Authorization must be renewed each school year or when there is a change in medication, dosage, or frequency.
- A written order from the prescribing, licensed practitioner is necessary to provide any medications or treatments at school.

Authorization:

1. The purpose of this consent form is to authorize for the safe and necessary administration of medication and treatments in school as ordered by my Health Care Provider (HCP) in my child's *(check all that apply)*:

   ____ **Anaphylaxis Action Plan** ____ **Asthma Action Plan** ____ **Diabetes Management Plan**

2. As indicated in the above **Plan(s)** signed by the HCP my child has permission to *(check all that apply)*:

   ____ **Self-Carry Medication(s)** ____ **Self-Administer Medication(s)**

3. Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
4. Information regarding this order will only be given to Saint Paul Public Schools staff who need this information for your child's/ adolescent's safety and education.
5. The prescribing health professional may **release information to** the Saint Paul Public Schools (SPPS) Professional Staff, and/or **request information from** SPPS Professional Staff related to the authorized service(s).
6. SPPS Professional Staff may **release information to** the prescribing health professional and/or **request information from** the prescribing health professional related to the service(s).
7. This authorization expires one year from the date of signature and may be revoked in writing at any time by notifying the school nurse.
8. A photocopy/fax of this authorization which has not *been altered will be treated in the same manner as the original.*
9. I recognize that health records, once received by the school district, may no longer be protected by HIPAA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

_____ (____) _____ (____) _____

Signature of Parent/Guardian | Phone *(Home/Cell/Work)* | Phone *(Home/Cell/Work)* | Date

Third Party Reimbursement:

- The purpose of this consent is to obtain insurance information to allow SPPS to seek reimbursement from third party payers for health care services.
- You may refuse to authorize the insurance information. Failure to sign may result in a referral to your primary health provider to receive this service.
- This consent may be revoked in writing at any time.
- Information regarding this medication order, the plan of care and health services documentation will be given to your insurance provider as requested for purposes of billing and quality assurance.
- Please check type of insurance: ____ Medical Assistance (MA) ____ Minnesota Health Care Program
  ____ Private insurance *(please attach a copy of your insurance card.)* ____ None

I authorize release of information regarding this medical order, the plan of care, and health related services documentation to third party payers or others for the purpose of billing and authorized payment directly to the Saint Paul Public Schools for any health care benefits due under the terms of this insurance policy for services rendered.

_____ (____) _____ (____) _____

Signature of Parent/Guardian | Phone *(Home/Cell/Work)* | Phone *(Home/Cell/Work)* | Date

Return to:

School Health Office at: _____

School Nurse: _____ Phone: (651) _____ Fax: (651) _____