



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

Procedure for Medications at School:

School Year _____

- Medications/treatments required must be administered or delegated by the school nurse.
- 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.
2. Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
3. Information regarding this order will only be given to Saint Paul Public Schools staff who need this information to provide your child's/ adolescent's education.
4. 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.
5. 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.
6. The authorization expires one year from the date of signature and may be revoked in writing at any time.
7. A photocopy/fax of this authorization which has not *been altered will be treated in the same manner as the original.*
8. 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 **Home Phone** **Work Phone** **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 (Student's MA# _____
 Please circle one: Straight MA / HealthPartners Care / U Care / Blue Plus / Medica Choice Care / Other _____
 _____ No insurance _____ Private insurance. Please attach a copy of your insurance card.

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 **Home Phone** **Work Phone** **Date**

CIF: _____ TO BE COMPLETED BY PRACTITIONER LICENSED TO PRESCRIBE				
Student's Name _____	M	F	_____	
Last	First	Middle	Birthdate	
Medication/Treatment _____				
		Dosage	Route	Frequency
Diagnosis _____			ICD-9 # _____	Effective date _____
				Discontinuation date _____
Signature of Practitioner Licensed to Prescribe _____		Print Name _____	Date _____	Phone _____
Address _____		City, State, Zip _____		Fax _____

*** Please ask the pharmacist to provide two labeled containers: ***
1 for home and 1 for school.

Return to: School Nurse _____ Phone _____ Fax _____
 School _____