AUTHORIZATION/PARENTAL CONSENT
FOR SCHOOL TO PROVIDE OVER the COUNTER MEDICATION
DISPENSE AS DIRECTED ON PACKAGE

NOTE: Use a separate authorization form for each medication. Provide the school with a new form each school year, each time the student has a new medication, when the District assigns a new medication provider to the student, and each time there is a change in the student's current medication regimen.

Student's last name: _____

Student's first name: _____

Gender: _____ Grade: _____

EMERGENCY / PARENT CONTACT INFORMATION

Parent/guardian's emergency contact number:
_____ ☐ Home ☐Work ☐Cell

Secondary family member's information:
_____ ☐ Home ☐Work ☐Cell

Primary healthcare provider's name and phone number:
_____ Phone: _____

STUDENT HEALTH INFORMATION

Does the student have any known allergies? ☐ Yes ☐ No
If yes, attach a list of known allergies to this form and certification from a healthcare provider that the student is not known to be allergic to any medication the school is requested to provide.

The student has knowledge of his/her known allergies and has been educated on the signs and symptoms of allergic reactions and how to prevent them. ☐ Yes ☐ No

Will the student be taking more than one medication at school or while otherwise under the school's supervision? ☐ Yes ☐ No
If yes, attach certification from a healthcare provider that the medications are not known to adversely interact or information on how to avoid any known adverse interactions.

MEDICATION AUTHORIZATION – PROVIDE AS DIRECTED ON PACKAGE

*NOTE: Fields marked with an * must be completed by a parent/guardian.*

*Medication's name: _____

Dates medication must be provided at school:
☐ Short term, list dates to be given: _____
☐ Every day at school until:
☐Medication is gone ☐End of the school year ☐Other: _____

☐ Episodic/Emergency Events ONLY (explain): _____
_____
_____

Time(s) of day*: _____

NOTE: If request is to provide medication after school hours when the student is under district supervision, the parent/guardian must work with the building Principal to develop a plan for coordinating this request.

*Serious reactions/adverse side effects from this medication may occur: ☐Yes ☐ No
*If yes, describe:_____

_____

_____

*Action/treatment for reactions:

_____

*Special handling instructions: ☐Refrigeration ☐Keep out of sunlight
☐Other: _____

*Is any dispensing equipment or other medical equipment required in order for the student to receive medication? ☐Yes ☐ No
*If yes, describe equipment and any special storage instructions: _____

_____

_____

OTC MEDICATION CHECK IN REQUIREMENTS FOR PARENTS

All over-the-counter medication supplied by the student's parent or guardian, must be supplied in the original manufacturer's container, and the container must list the ingredients, recommended dosage, expiration date, administration instructions, and storage instructions (if any) in a legible format. The container must be labeled with the student's name and, if unsealed, the number or amount of medication in the container.

If this request is to provide OTC medication in any way that deviates from the recommended manufacturer's directions approval must be received from an appropriate healthcare provider. This healthcare provider must complete form ACBD-E3

Reminder - All medications must be delivered, in person, by the child's parent to the office.

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CONFIDENTIALITY WAIVER

NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA).

I _____ (parent/guardian's name) authorize (name of agency and/or health care providers): _____ to provide health information from _____(student's name) medical record to: Jamestown Public School. The disclosure of health information is required for the school to provide medication.

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for the remainder of the school year from the date of signature (if no date entered).

Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____

Parent/guardian's signature Date

NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider upon completion.

PARENTAL CONSENT

I am the parent or guardian of _____. I give my permission for him/her to take the following medication while in Jamestown Public School. I authorize the district to provide medication to my child:

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I hereby release Jamestown Public School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____

Parent/Guardian Signature Date