

**ONONDAGA CENTRAL SCHOOL DISTRICT
PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL**

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Signature (Parent or Person in Parental Relation): _____

Address: _____

Telephone: Home _____ Cell _____ Work _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of student: _____ Date of birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendation: _____

I assess this student to be self-directed Yes No

Student may self-carry and self-administer medication Yes No

Please complete the Self-Medication Release Form and Attestation Form with this option. Nurse will also assess self-direction for the school setting.

Name of Licensed Prescriber and Title (please print): _____

Prescriber's signature: _____ Date: _____

Address: _____ Phone: _____

ONONDAGA CENTRAL SCHOOL DISTRICT
Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize Onondaga Central School District to display and publish my child's life-threatening health concerns listed below on the school information system (_____.) I understand that this information will be accessible to all Onondaga Central School District employees.

The Protected Health Information may be used, disclosed or received for the following purpose (s):

- *To adhere to emergency plans of care as advised by health care professionals
- *To develop care or therapy plans for routine and emergent school management
- *To design appropriate educational, school or athletic programs
- *To assess the impact of the medical condition(s) on school programming and/or attendance
- *To share school observations/concerns
- *To assess a medical basis for modification of transportation and/or home tutoring
- *Medication delivery or therapy prescriptions

Other _____

Student Name _____

Life Threatening Health Condition(s) _____

This authorization is valid for the duration of attendance within the school district

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the District Administration Building. I understand the revocation of this authorization is not effective if the District has used the authorization for disclosure of Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal and state law. I understand that Protected Health Information will not be disclosed to entities outside of the Onondaga Central School district. I understand that Protected Health Information will be disclosed to Onondaga Central School district employees who have a need to know. I understand that my child's treatment is not dependant on my agreement to release or withhold information. I give permission for the school representatives to share and disclose information as indicated above with the appropriate school district employees.

Signature of Parent/Guardian or student if over 18

Date

Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD