



## Authorization for the Administration of Medication/Treatment

HIPAA-Compliant Authorization for Exchange of Health & Education Information

Student: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ CIF: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone (Home/Work/Cell): (\_\_\_\_) \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Clinic Location: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### 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 in my child's *(check all that apply)*:

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

**Seizure Action Plan**       **Other** *(Please specify name of plan):* \_\_\_\_\_

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 The Journey School professional staff who need this information for your child's/adolescent's safety and education.
4. The prescribing health care provider may **release information to** and/or **request information from** TJS professional staff related to the authorized service(s).
5. TJS professional staff may **release information to** and/or **request information from** the prescribing health care provider related to the service(s).
6. I understand that:
  - This authorization takes effect the day that I sign it and expires one year from the date of my signature.
  - I may revoke this authorization at any time by giving written notification.
  - Health records, once received by the school district, may no longer be protected by Health Insurance Portability and Accountability Act (HIPAA), but they will become education records protected by Family Educational Rights and Privacy Act (FERPA).
  - Educational records, once received by another individual or agency, may no longer be protected by FERPA, but may be protected by HIPAA.
  - This information, except as allowed by law, may not be re-disclosed without my consent.
  - A photocopy/fax or electronic copy of this authorization, which has not been altered, will be treated in the same manner as the original.

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**Signature of Parent/Guardian/Adult Student**

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**Date**

Return to:

School Office at [office@thejourneyschool.org](mailto:office@thejourneyschool.org) or Papercopy to office

Fax- 612-246-3958

## Authorization for Administration of Medications

Please sign this form to allow The Journey School health staff to give medication and treatments in school as directed by your child's healthcare provider. This form also allows TJS professional staff and your healthcare provider to share and request information from each other. Legally, you may refuse to sign. If you refuse, we will not be able to provide these services.