Parent/Guardian Authorization for the Administration of Over-the-Counter Medication

(Medication must be in original bottle and directions must follow package guidance)

Student: _____ DOB: _____ ID: _____

Parent/Guardian: _____ Phone: _____

Medication Name:_____ **Dose:**_____

Directions:_____

_____

Purpose:_____

Authorization

- The purpose of this consent is to authorize for the safe and necessary administration of over-the-counter medication.
- My child has permission to (check all that apply):
  ___ Self-Carry Medication ___ Self-Administer Medication if approved by the Licensed School Nurse. **Students must be in grades 6-12 to self-carry over-the-counter pain medication. Students may not self-carry or self-administer any drug or product containing ephedrine or pseudo-ephedrine.**
- Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
- Information regarding this medication will only be given to Saint Paul Public Schools professional staff who need this information for your child's safety and education.
- Medication will be provided by the parent/guardian, in the original container.
- SPPS professional staff may request medical orders if the medication directions differ from those listed in the package insert.
- 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

_____ _____

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

Return to The Journey School Office