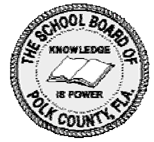
Authorization for Medication /Treatment



The following section is to be completed and signed by the PARENT:

A new authorization **must** be completed at the beginning of **each** school year or anytime a dosage is changed.

Revised 5-06

Child's Name ______________________________ ____ ____ ________

Last | First | Sex | Grade | Date of Birth

______________________________ ________________

Physician's Name | Address | Emergency Phone

I hereby authorize the above named physician and Polk County Schools/Polk County Health Department staff to reciprocally release verbal, written or faxed protected health information (PHI) regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand PHI is confidential and is protected by the Health Insurance Portability and Accountability Act (HIPAA).

I request that my child be assisted in taking the medication or treatment described below at school by authorized persons as permitted by me and my physician (*see below*).

________ ________________ ____________ ____________

Date | Parent/Guardian Signature | Home Phone | Emergency Phone

The following section is to be completed by the PHYSICIAN:

(***ONLY ONE*** *medication or treatment per form)*

Diagnosis for which medication or treatment is given:

Name of medication or treatment: ________________________________

Form: ________________________________

Dose: ________________________________

If medication or treatment is to be given at school, at what time? ________________

If medication or treatment is to be given "When needed",
describe indications: ________________________________

How soon can it be repeated? ________________________________

List significant side effects: ________________________________

Length of time medication/treatment is recommended:

Other information:

____

____

____

Place Office Stamp Here

________ ________________________

Date | Physician's/Mid-level Practitioner's Signature

Adapted from the American College of Allergists