PARENT REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

Student Name: _____ Date of Birth: _____
Address: _____ Phone: _____
School: _____ Grade: _____ Parent(s): _____
Medical Diagnosis: _____

I request and authorize designated school personnel to give the medication listed below to my child. I release school personnel from any liability should reactions result from the medication. I give my permission for the School Nurse to contact my physician / dentist regarding this medication. I understand that pertinent information will be shared with appropriate school staff.

Medication to be taken at school:

Name of Medication:	Dose	Time to be given
_____	_____	_____
_____	_____	_____

Functional restrictions or side effects from medication:
_____

I hereby authorize release of information between
_____
(name and address of doctor or clinic)
and Duluth Edison Charter Schools, ISD 4020

Information to be released:
Medication orders for the administration of medication during the school day

_____ _____
Physician's signature *Date*

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one (1) year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I will receive a copy of this form upon my request.
- I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervision inspection of medical records.

_____ _____
Signature of parent/guardian *Date*