NORTHERN LIGHTS PEDIATRIC
& ADOLESCENT MEDICINE

www.NorthernLightsPediatrics.com

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Authorization for Administration of Medication at School

Name of Student: ______________________ DOB: __________

School: ______________ School Year: __________ Grade: ________

Name of Medication: ______________________ Strength: _______

Dosage: ______________ Time: __________ Route: ____________

Reason for Medication: ______________________________

Possible side effects: ______________________________

Start Date: ________________ Stop Date: ________________

(All authorizations expire at the end of the school year)

____ Student is knowledgeable about the medication and how to administer it.

____ Student may self-administer the medications. (Not applicable for controlled substances.)

________________ ________________ ________

Physician Signature Printed Name Date

1. I request that the above medication be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reaction result from taking the medication.
3. I will notify the school of any change in the medication. (ex. dosage change, medication is discontinued, ect.)
4. I give permission for the school nurse to communication with the student's teacher about the student's health condition and the action of the medication.
5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding and questions that arise with regard to the listed medication or medical conditions being treated by this medication.
6. I give permission for the medication to be given by designated personnel as delegated by the school nurse.

___ My son/daughter may self-administer his/her medication. (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, and etc.)

________________ ________________ ________

Parent/Guardian Signature Relationship to Student Date

MEDICATION IS TO BE SUPPLIED IN THE ORIGINAL/PERSCRITION BOTTLE

Vadnais Heights:
3555 Willow Lake Blvd, Suite 140, Vadnais Heights, Minnesota 55110 • (651) 770-2124 Fax: (651) 770-3701
Hugo Clinic:
14712 Victor Hugo Blvd, Suite 40, Hugo, Minnesota 55038 • (651) 777-2362 Fax: (651) 770-3701

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Release of Information

Patient Information	**Name:** ______ **Date of Birth:** ______ **Address:** ______ **Phone Number:** ______ **City:** ______ **State:** ______ **Zip:** ______
Clinic/Hospital/Health Care Provider (**Who** has the information you want released?) **Please list the specific clinic and/or hospital.**	**Name:** ______ **Address:** ______ **Phone:** ______ **City:** ______ **State:** ______ **Zip:** ______ **Fax Number:** ______
Receiving Party (**Where** do you want the information sent?)	**Name:** ______ **Address:** ______ **Phone:** ______ **City:** ______ **State:** ______ **Zip:** ______ **Fax Number:** ______
Information to be Released (**What** do you want sent or released? Check the appropriate box.)	□ Specific dates/years of treatment ______ □ ALL health records Or ONLY records types checked below □ History/Physical □ Progress notes □ Consultations □ Lab report □ Care Plan □ Other information or instructions ______ □ Medication □ Immunizations ______ □ Mental health □ Radiology Repots
Release Instructions	Date information is needed: ______ (Please allow 7-10 days for processing)
Purpose of Release	□ Continuation of Care by specialist □ Insurance □ Transfer of Care □ Personal Use □ Other ______

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: ______
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Northern Lights Pediatrics will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Only one free copy of records will be released (unless requested by a specialist, insurance company, or lawyer), if subsequent records are needed there may be a charge.
- Northern Lights Pediatrics records may include records that it received from other organizations. If these records have been used by Northern Lights Pediatrics authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Northern Lights Pediatrics from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

______

Patient/Legal Guardian Signature Date Relationship to Patient