

**Hiawatha Valley Education District**  
**Medication/Treatment Authorization Form**  
*(Has been determined HIPAA compliant)*  
(Parent and Licensed Prescriber/Physician)

Student Name:

DOB:

MR#:

HCL#:

Label or Addressograph

*Retain the Medication/Treatment Authorization Form for future use*

**PARENT – PLEASE COMPLETE**

Parent/Guardian: Communication between the medical community and your child's school provides for positive health outcomes for students, families and community.

Completion of this form and returning it to your student's school enhances coordination of services and promotes an optimal learning environment.

Please fax this form to my student's school:

River Valley Academy, PO Box 7, Kellogg, MN 55945

Fax Number: 507-767- 3232

I will provide this form to River Valley Academy for the 2011-2012 school year.

1. I request that the medication(s) and/or treatment(s)/procedure(s) specified on this form be given during school hours as ordered by this student's physician/licensed prescriber.
2. I release school personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).
3. I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
4. I give permission for the school nurse to communicate with the student's teachers about my student's health condition (s) and the action of the medication(s) and/or treatment(s)/procedure(s).
5. I give permission for the school nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
6. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designed personnel as delegated by the school nurse.
7. **I understand that school health personnel cannot administer the medication(s)/treatment(s)/procedures(s) indicated on this form without authorization from my student's physician/licensed prescriber.**

Additional Information:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Relationship to Student

