

**SOUTHWEST COOK COUNTY COOPERATIVE  
ASSOCIATION FOR SPECIAL EDUCATION**

**MEDICATION(S) – PARENT/PHYSICIAN AUTHORIZATION**

Student Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Program/Location: \_\_\_\_\_

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>ROUTE OF ADMINISTRATION</u>	<u>TIME OF ADMINISTRATION</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Condition and purpose for which medication prescribed: \_\_\_\_\_

Necessity for medication during school hours: \_\_\_\_\_

Comments (Include special instructions, possible side effect, etc.): \_\_\_\_\_

\*When "PRN" is noted, please list specific conditions, which would warrant administration: \_\_\_\_\_

Above student may safely self-administer above-listed medications.  Yes  No

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(Where a physician can be reached in an emergency)

.....  
**PARENT AUTHORIZATION:** Regarding the above listed medication(s), I hereby authorize the:

1. Administration of medication to my child by individual as specified in SWCCCASE Medication Administration Policy  Yes  No

2. Self-administration of medication by my child by individuals as specified in SWCCCASE Medication Administration Policy  Yes  No

I have received a copy of said policy and am familiar with its contents. I further authorize the release and exchange of information between SWCCCASE and the following physician(s) or agency(ies) regarding above listed medication(s):

\_\_\_\_\_

This authorization is valid for one calendar year and will expire on \_\_\_\_\_. I understand that I may revoke this authorization in writing at any time. I understand that my revocation of this authorization will not be effective for actions taken in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment provided to my child. I understand that health or education records once received by an authorized third party that is not a covered entity or related to SWCCCASE, may not be protected by the HIPAA Privacy Rule or the Family Educational Rights and Privacy Act. I understand that health records, once received by SWCCCASE, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain emergency health care. I also understand that I have the right to a copy of this document, the right to see and copy all health information used or disclosed, and the right to inspect and copy educational records and to challenge their contents.

\_\_\_\_\_  
Parent Signature (do not sign until completed) Date

\_\_\_\_\_  
Student Signature \* Date

\_\_\_\_\_  
Witness Signature Date

\* Student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records.

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_