FINAL 11/06

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #

Parent/Legal Guardian _____ Telephone # _____

Mailing Address _____

PART 2: RECORD REQUEST

Complete box A **OR** box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3:

- ❑ COMPLETE RECORD(S)
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Consultation
- ❑ Progress Notes
- ❑ Cardiopulmonary
  (Indicate EKG, Stress Test, Sleep Study)
- ❑ Emergency Room
- ❑ Lab
- ❑ Pathology
- ❑ Radiology Results
- ❑ Other _____

_____

B. If initialed below, I specifically authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

_____
Initials of parent/legal guardian

PART 3: AUTHORIZATION

This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: _____ (School System)

❑ **TO RELEASE Information TO** **AND/OR** ❑ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): _____

The information is to be released for the purpose(s) of:

- ❑ Evaluation to determine eligibility or continued eligibility for special education services
- ❑ Providing physical therapy treatment
- ❑ Providing occupational therapy treatment
- ❑ Designing an individual educational program
- ❑ Determining appropriate placement for treatment needs
- ❑ _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

_____	_____	_____
Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18)	Date	(Relationship to student)

_____	_____
Signature of Witness	Date

EBRP PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

(Please Print)

Student: _____ Birthdate: _____ Grade: _____

School: _____ Teacher: _____

Parent/Guardian: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Other persons to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medication to be given at school: _____

Special Instructions for giving your child this medication: _____

List all allergies: _____

List all medications student takes at home: _____

The following questions must be answered in order for your child to receive medications at school; all answers must be "Yes" before the medication can be administered at school by unlicensed trained personnel.

1. Have you received and reviewed the EBRP School Board Medication Policy? **Yes__ No__**
2. Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your child relative to medication administration as the nurse deems necessary? **Yes__ No__**
3. Are there any restrictions on this release? _____
4. Do you understand that you may retrieve the medication from the school at any time and that the medication will be destroyed after you have been notified if it is not picked up within two weeks following the end of the term or when the medication orders are discontinued? **Yes__ No__**
5. Have you administered the initial dose at home and have you allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication? **Yes__ No__**

Use this box ONLY for a student who will administer his/her own medication, such as asthma inhaler. The student will be required to record each dose.

1. Do you give permission for your child to self administers medication if the school nurse determines it is safe and appropriate in the school setting? **Yes__ No__**
2. Do you believe your child is sufficiently responsible and informed to administer his/her own medication? **Yes__ No__**
3. Do you assume responsibility for your child's actions in his/her self management of medication at school? **Yes__ No__**
4. Do you understand that regular medication orders must be provided by a physician for students who self administer medications at school? **Yes__ No__**

I understand and agree that EBRP School Board and its employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold the School Board free and harmless from liability from injuries which might occur as a result of the administration of medications by school employees.

_____ _____

Parent/ Guardian Signature Date