Blochman Union School District

BENJAMIN FOXEN ELEMENTARY SCHOOL

4949 Foxen Canyon Road
Santa Maria, CA 93454
(805) 937-1148 • FAX (805) 937-2291

PARENT CONSENT FOR RELEASE OF INFORMATION

Student's Name: _____ Date of Birth: _____

I authorize the following individual or organization to disclose the above named individual's health /education information as described below:

Information to be released and received by :	Information to be released and received by:
_____ Name of Professional or Agency _____ Address _____ Phone _____ Fax	Blochman Union School District Name of Professional or Agency 4949 Foxen Canyon Rd. Santa Maria, CA 93454 Address (805) 937-1148 Phone (805) 937-2291 Fax

In signing I confirm that information and communication may be exchanged between the parties regarding the following:

- ☐ Educational
- ☐ Psychological
- ☐ Medical
- ☐ Developmental
- ☐ Other: _____

I request that the information released be used for the following purposes only:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

I understand that I have the right to revoke this authorization in writing. Written revocation is effective upon receipt, but will not apply to information provided prior to written revocation. I further understand that health information may be redisclosed to necessary school personnel within the receiving agency. The confidentiality of the information when released is protected as a student record under the Family Educational Rights and Privacy Act (FERPA). This agreement is effective for one year from the date of signature or until _____.
I understand I have a right to receive a copy of this authorization.

Any information received by the public school must, by law, be included in the student's records. A copy of this authorization is valid as an original.

_____ _____ _____
Signature Relationship to Student Date

School Year:_____

BLOCHMAN UNION SCHOOL DISTRICT

Health Services

Authorization to Administer Medication(s)

Student Name:_____DOB:_____Grade:_____

School:_____Phone:_____ Fax:_____

To: Parent/Guardian and Physician

If a medication must be taken during the school day or during a school sponsored overnight trip, it is necessary, in accordance with **California Education Code Section 49423,** to have a written statement on file. The statement must be signed by the parent/guardian and the physician indicating a desire that designated school personnel assist the student with medication administration. **The authorization must be made annually and/or whenever a change occurs.**

Education Code requires that **ALL** medications, **prescription** and **over-the-counter** must have a completed statement from **BOTH** the physician **AND** parent/guardian **BEFORE** they can be administered. Medication must be provided in the **original container** labeled with the students name, medication name, dose/strength and **specific** administration directions.

Parent/Guardian Authorization

As the parent/guardian of the above named child, I request that designated school personnel assist in the administration of medication prescribed by the physician. I give consent for the physician and designated school personnel to communicate directly, regarding the administration of the medication. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I understand that the medication will be stored in a locked area.

Signature:_____Date_____

Physician Authorization

As the physician of the above named child, it is, in my professional opinion appropriate and necessary that the following medications be available for administration during the school day or during extended hours when the child is on school sponsored trips/outings/events.

Please place an "X" through any unused columns.

Name of Medication(s)	1.	2.	3.
Purpose of Medication			
Strength/ Dose			
Medication form (liquid, tablet, inhaler, etc.)			
Route of administration (oral, inhaled, injected, etc.)			
Scheduled administration time(s) or frequency if PRN			
Duration of need (if other than entire school year).			
Precautions, instructions, adverse effects or comments			
Physician Signature:			**Date:**
Print Name:			**Phone:**