



## Authorization for the Administration of Medication/Treatment

Student name: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Parent/Guardian phone number: \_\_\_\_\_ Email: \_\_\_\_\_

### To Be Completed by Practitioner Licensed to Prescribe

Clinic Name: \_\_\_\_\_ Licensed Practitioner: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Effective date: \_\_\_\_\_

Medication/Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
Signature of Practitioner Licensed to Prescribe

\_\_\_\_\_  
Date

#### Authorization:

1. Legally, you may refuse to sign. If you refuse, we will not be able to provide the services.
2. Information regarding this order will only be given to Circus Juventas staff who need this information for your child's safety and well-being.
3. The prescribing health care provider may release information to and/or request information from Circus Juventas staff related to the authorized service(s).
4. This information, except as allowed by law, cannot be re-disclosed without your consent.
5. Health records, once received by another agency, may not be protected by the HIPAA Privacy Rule.
6. This authorization is valid for one calendar year.
7. You may revoke this authorization at any time by submitting written notice of the withdrawal of your consent.
8. A photocopy/fax or electronic copy of this authorization, which has not been altered, will be treated in the same manner as the original.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Return to: Circus Juventas c/o Marissa Dorschner

[marissa@circusjuventas.org](mailto:marissa@circusjuventas.org)

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