CIRCUS JUVENTAS
501 (C)(3)

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 - Summer Camp

summercamp@circusjuventas.org 1270 Montreal Ave, St. Paul, MN 55116 651-699-8229