Authorization for Administration of Medication
By Cosumnes Community Services District Personnel
(Please note: this form must be completed each school year, or more frequently as necessary)

Participant's Name _____ **Age** _____ **D.O.B** _____
Tiny Tot Preschool Site _____

PHYSICIAN INSTRUCTIONS – Please Note: medical personnel are not available during the Preschool program. Whenever possible, please prescribe medication that can be given outside of the normal preschool day. If medication must be administered during Tiny Tot Preschool program hours, please complete the information below.

Medication	Dosage	Route of Administration	Time of Day

Diagnosis or indication for medication _____
Length of time to be taken _____
Precautions, if any _____

a. For emergency medication, is the child capable of self-administering the necessary treatment/medications?
Yes ___ No ___
b. Will the child need to carry this medication on his/her person? Yes ___ No ___
c. Will the child need to self-administer this medication? Yes ___ No ___

Please note the obvious side effects of this particular medication _____
_____

PHYSICIAN'S CONTACT INFORMATION

Physician's Name	
Physician's Address	
Physician's Phone Number	

Physician's Signature _____ **Date** _____

PARENT'S REQUEST

I/We the undersigned, who is/are the parent/guardian of _____ request that medicine be administered to the said child by a designated member of the CCSD Staff, in accordance with the instructions outlined above and signed by our physician. It is to be given at _____ (time) with the following special instructions _____. In agreeing to have the Tiny Tot Preschool Staff administer our son/daughter's medication, I voluntarily agree to release, discharge, and hold harmless Cosumnes Community Services District and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act or omission which causes our child's illness, injury, death, and damages of any nature in any way connected with the administration of our child's medication.

As indicated in the physician's statement above, our child _____ will self administer his/her own emergency medication when required, and we are not requesting Cosumnes Community Services District personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her emergency medication during program hours because he/she suffers from the following life threatening condition _____ (state nature of illness). Our child will need to take his/her medication _____ (# of times/day) with the following special instructions: _____
_____.

I understand the major responsibility for a child taking medication rests with the child and his/her parents/guardian, and we are required to personally bring the medication to the Tiny Tot Preschool program.

_____ _____ _____
Parent/Guardian Signature Date Day Time Phone

Emergency Contact: _____ Phone: _____