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** ________
Kid Central Site(s) ____

PHYSICIAN INSTRUCTIONS – Please Note: medical personnel are not available during the Kid Central program. Whenever possible, please prescribe medication that can be given outside of the normal work day. If medication must be administered during the Kid Central 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 Cosumnes CSD 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 Kid Central 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 Kid Central program.

_________________________________ _________ ___________________________________
Parent/Guardian Signature Date Day Time Phone

Emergency Contact: ________________________________ Phone: _______________________