Authorization for Administration of Medication by Cosumnes Community Services District Personnel

2018-2019 Program Year

(Please note: this form must be completed each school year, or more frequently as necessary)

PARTICIPANT'S NAME ____ **AGE** ________ **D.O.B** ________________

During what program(s) does child need medication? (Check all that apply)

☐ Kid Central Youth Center Day Camp ☐ Kid Central Before/After School: (school site:) ______________________________

PHYSICIAN INSTRUCTIONS - Please note: medical personnel are **not** available during CSD Kid Central Programs. Whenever possible, please prescribe medication that can be given outside of the normal work day. If medication must be administered during 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. Can the child self-administer this medication? Yes ___ No ___

Please note the obvious side effects of this particular medication: ____
____

PHYSICIAN CONTACT INFORMATION

Physician's Name		Physician's Phone #	
Physician's Address			

Physician's Signature ____ Date ______________________

PARENT'S REQUEST **(please check your request)**

☐ I/We the undersigned, who is/are the parent/guardian of *(child's first and last name)* _________________________________ 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 my/our physician. It is to be given at *(time)* ____________ with the following special instructions _________________________________ ______________________________. In agreeing to have the CSD Staff administer my/our son's/daughter's medication, I/we 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 my/our child's illness, injury, death, and damages of any nature in any way connected with the administration of my/our child's medication.

☐ As indicated in the physician's statement above, my/our child *(child's first and last name)* ________________________ will self-administer his/her own medication when required, and I/we are not requesting Cosumnes Community Services District personnel to assist in the administration of my/our child's medication. My/Our child will need to self-administer his/her medication during program hours because he/she has the following condition *(state nature of illness)*____. My/Our child will need to take his/her medication *(# of times)* ___________ **per day** while at the CSD Program with the following special instructions: ____________________________________.
In agreeing to have my/our child self- administer his/her own medication, I/we 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 my/our child's medication.

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 CSD Kid Central in its original packaging.

____ ________________ ______________________________________
Parent/Guardian Signature Date Day Time Phone

Emergency Contact: ____ Emergency Contact Phone: ________________________