Parent Authorization and Waiver for Student to Self-Administer Medication

STUDENT INFORMATION:

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ School Year: _____

It is the policy of Citizens of the World Charter Schools – Los Angeles ("CWC LA") that any pupil who is required to take medication during the regular school day may self-administer the medication only if the School receives: (1) a written statement from the physician detailing the name, method, amount, time schedules, discontinue date, any known drug allergies or reactions of the medication, and confirmation that the medication may be self-administered; and (2) a written statement from the parent or guardian consenting to the self-administration, providing a release for the School to consult with the student's physician/health care provider, and releasing the School from liability.

Authorization for My Child to Self-Administer Medication

By signing and submitting this form, I hereby consent to my child's self-administration of medication related to my child's asthma, diabetes, and/or allergic reactions, as described in the attached statement of my child's physician/health care provider. I hereby authorize my child to carry and self-administer his/her (initial all the apply):

_____ Asthma inhaler

_____ Diabetes medication

_____ Epinephrine auto-injector (EpiPen®)

_____ Other: _____

I further agree and understand that my child must follow the applicable CWC LA policies and appreciate the responsibility of carrying his/her medication. I also understand that a student may be subject to disciplinary action if the self-administered medication is used in any manner other than prescribed by the student's physician/health care provider.

Authorization to Consult with Physician/Surgeon/Health Care Provider

I permit an authorized representative of CWC LA to communicate, exchange, release, and deliver information directly with my child's physician/health care provider, _____, as may be necessary, regarding any questions that may arise with respect to the medication, and for my child's physician/health care provider, _____ to communicate, exchange, release, and deliver information directly with CWC LA regarding the same. I understand and agree that this authorization for exchange of information between CWC LA and my child's physician/surgeon or health care provider, shall be in effect for the duration of the current school year, or as long as my child is prescribed or ordered to take medication at sschool during the current school year, whichever expires sooner.

Release of Liability and Agreement to Indemnify and Hold CWC LA Harmless

I hereby expressly release, hold harmless, and agree to indemnify and defend CWC LA and School and its Governing Board members, officers, employees, agents, representatives, independent contractors and insurers from all claims and liability for any personal injuries, death, or property damage that may be incurred if my child suffers an adverse reaction as a result of the self-administration of his/her medication as set forth above. This release, hold harmless, and indemnification agreement shall remain in effect until a written notice to terminate the agreement is received and acknowledged in writing by the School's Principal.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Physician Authorization

As the physician, surgeon, or physician assistant of the child identified above, I confirm that the child is able to self-administer auto-injectable epinephrine and/or inhaled asthma medication, as needed and as further set forth below.

Name of Medication: _____

Purpose: _____

Dosage: _____ As Needed (PRN) Frequency: _____

Method of Administration: _____

Time medication is to be administered: _____ Under what circumstances: _____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Known allergies and/or reactions to this medication, if any: _____

_____

Medication may be Self-Administered (circle one): **YES** **or** **NO**

Comments: _____

_____

Health Care Provider Name Phone (include area code)

_____

Health Care Provider Signature Date

STAMP