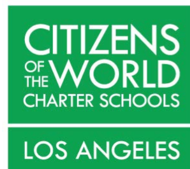

Parent Request for Assistance with Administering Medication

STUDENT INFORMATION:

Last Name: ______________________________ First: ______________________Middle: ____________________

Date of Birth: ______________________ School Year: _______________

Before any prescription or over-the-counter medication(s) can be administered by Citizens of the World Charter Schools – Los Angeles ("CWC LA") staff at school this Medication Authorization Form MUST be completed by the student's parent(s)/guardian(s) and the student's physician prescribing the medication. A new form must be completed every school year and/or at the time the student's medication, dosage, frequency of administration, or reason for administration of the medication changes.

All Medication must be provided in the original container labeled with the student's name, medication name, dose/strength and specific administration directions.

It is the policy of CWC LA that any pupil who is required to take, during the regular school day, medication prescribed for her/him by a physician and/or surgeon, may be assisted by designated school personnel if the School receives: (1) a written statement from the physician or surgeon or physician assistant detailing the name, method, amount, time schedules, discontinue date, and any known drug allergies or reactions, of the medication to be administered; and (2) a written statement from the parent or guardian indicating the desire that the School assist the pupil in the matters described in the physician statement.

Parent/Foster Parent/Guardian Authorization to Assist with Administering Medication

By signing and submitting this form, I hereby consent to and authorize the designated CWC LA school personnel to assist my child with the administration of the medication as set forth in the attached Physician/Surgeon Authorization. By signing below, I further acknowledge and agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, or as set forth in the attached Physician/Surgeon Authorization, I hereby authorize designated personnel of CWC LA, on my behalf, to administer or to attempt to administer to my child, lawfully prescribed or over-the-counter medication in the manner described below. I further acknowledge that it may be necessary for the administration of medication(s) to my child to be performed by a designated staff member other than a school nurse and specifically consent to such.

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.

I further understand and agree that CWC LA policies and procedures require that my child's medication be provided in the original container labeled with the student's name, medication name, dose/strength and specific administration directions to be stored in in its original container in a secure place, under the direction of designated personnel of CWC LA, and not carried by or in the possession of my child, unless otherwise ordered by the student's physician/surgeon or health care provider.

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____Date: ____________

PHYSICIAN AUTHORIZATION

As the physician, surgeon, or physician assistant of the child identified above, I hereby confirm that the child has been prescribed the following medication(s) that shall be administered in accordance with my instructions below.

Medication Name	**Medication #1**	**Medication #2**	**Medication #3**
Method of Administration			
Amount/Dosage			
Time/Frequency Schedule(s) for Administration of Medication			
Discontinuation Date			

Diagnosis requiring medication: ____

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

____

____
Health Care Provider Name Phone (include area code)

STAMP

____
Health Care Provider Signature Date