Science Discovery

UNIVERSITY OF COLORADO **BOULDER**

Permission to Administer Medication

Please Note: This form should only be completed if CU Science Discovery will be ADMINISTERING medication not already covered by the Allergy Care Plan or Asthma Care Plan.

This form WILL NOT be accepted without a physician's signature.

****THIS FORM IS DUE 30 DAYS PRIOR TO THE START OF YOUR CHILD'S PROGRAM****

In the event that your child needs to receive medication while participating in CU Science Discovery Programs, please complete this form in detail, providing your signature of permission and a physician's signature. Please carefully consider whether or not medication can be administered outside of CU Science Discovery Program times. Medication will only be administered by CU Science Discovery staff who have completed approved Medication Administration Training.

UNEXPIRED medication must arrive in its original container labeled with child's name and dosage. Parents are responsible for delivering the medication to CU Science Discovery. Your child will not be permitted to store medication in his or her backpack. Medication will be stored with child's instructor or with the director.

Student's Name: ____ Birthdate: ____________________

Parent/Guardian Name: ____

Home Phone: _______________ Cell Phone: __________________ Work Phone: _______________

Emergency Contact: _____________________________________ Phone: ____________________

Medication: ____

Dosage:__________________ Route:___________________ Time of Day to be given:_______________

Purpose of Medication:____

Special Instructions:____

Possible Side Effects:____

Start Date of Camp:______________________ End Date of Camp:______________________________

Health Care Provider Information
(Physician's signature indicates that a healthcare provider has approved this child to receive the indicated medication)

_______________________________________ ______________________
Physician's Name (Please Print) License Number

_______________________________________ ______________________
Physician's Signature and Title Phone Number
(A stamp is acceptable if title is present)

____
Date

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. The undersigned parent or guardian hereby agrees to release, defend, and indemnify the Regents of the University of Colorado, a body corporate, CU Science Discovery, and its officers, employees, and agents, from any legal claims arising out of the administration of (or failure to administer) the medications specified above. The undersigned parent or guardian understands that the University and CU Science Discovery are not responsible for the administration of any medication and will not administer medications other than those specified in the student's Medication Plan.

I give permission for CU Science Discovery personnel to share this information, follow this plan, administer medication, care for my student and, if necessary, contact the student's health care provider. I assume full responsibility for providing CU Science Discovery with prescribed medication and/or delivery/monitoring devices. I approve this Medication Plan for my student.

____ ________________
Parent/Guardian Signature Date