



**Cosumnes Community Services District  
Parks & Recreation Department**  
8820 Elk Grove Blvd  
Elk Grove, CA 95624  
(916) 405-5600



**ADMINISTRATION OF MEDICATION FOR PARTICIPANTS**

Dear Parent/Guardian,

The following information is designed to help you and your child comply with the Cosumnes Community Services District Policy and Procedures in relation to the Administration of Medication during the Kid Central program.

1. No medication (prescription or non-prescription including aspirin, cough drops, etc.) will be dispensed to students or allowed at any Kid Central program without the appropriate form being completed and on file at the Cosumnes Community Services District. If the physician requires a portion of a tablet, pill, etc., be dispensed, the parent/guardian is responsible for dividing the tablet into the prescribed size.
2. Participants requiring medications during the Kid Central program shall be identified to the Kid Central Program Staff by the parent/guardian and physician.
3. The Authorization for Administration of Medication by CCSD Personnel is located on the back side of this letter. If you have questions, please contact the Recreation Supervisor.
4. All participant medication must be in the original container clearly labeled with the child's name and will be kept securely locked in a Kid Central storage area or office. Participants may not carry medication on their person, although exceptions may be made for students who need medication for potentially life-threatening conditions. Such exceptions require physician, parent/guardian, and Recreation Director Authorization.
5. Parents/guardians are required to provide written verification from physician to the Cosumnes Community Services District of any change in the medication or dosage. Physicians may fax form (405-5659) to the Cosumnes Community Services District main office to authorize medication changes.
6. The Authorization for Administration of Medication by CCSD Personnel must be updated every school year and whenever any changes are made in the treatment plan.

Lana Yoshimura  
Director of Recreation Services  
Community Services Division  
Cosumnes Community Services District



**Authorization for Administration of Medication  
by Cosumnes Community Services District Personnel  
2025-2026 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 Off-Track Specialty Camp      ☐ Kid Central After-School Club

**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 their 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/GUARDIAN'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 child'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 their 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 their medication during program hours because they have the following condition (state nature of illness) \_\_\_\_\_. My/Our child will need to take their medication (# of times) \_\_\_\_\_ per day while at the CSD Program with the following special instructions: \_\_\_\_\_.

In agreeing to have my/our child self-administer their 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 their parent/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: \_\_\_\_\_