**Authorization for Administration of Medication**
**By Cosumnes Community Services District Personnel**

(Please Note: This form must be completed each school year or more frequently as necessary.)

**Participant's Name** _____ _____ **Age** _____ **D.O.B** _____

**Tiny Tot Preschool s Site**

_____ _____ _____

**PHYSICIAN INSTRUCTIONS** – Please Note: Medical personnel are not available during the Preschool program. Whenever possible, please prescribe medication that can be given outside of the normal preschool day. If medication must be administered during Tiny Tot Preschools 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. Will the child need to self-administer this medication? Yes ___ No ___

Please note the obvious side effects of this particular medication

_____

_____

**PHYSICIAN'S CONTACT INFORMATION**

| | |
|---|---|
| **Physician's Name** | |
| **Physician's Address** | |
| **Physician's Phone Number** | |

**Physician's Signature** _____ _____ **Date** _____

**PARENT'S REQUEST**

☐ I/We the undersigned, who is/are the parent/guardian of _____ request that medicine be administered to the said child by a designated member of the CCSD Staff, in accordance with the instructions outlined above and signed by our physician. It is to be given at _____ (time) with the following special instructions: _____. In agreeing to have the Tiny Tot Preschools Staff administer our son/daughter's medication, I 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 our child's medication.

☐ As indicated in the physician's statement above, our child, _____, will self-administer his/her own emergency medication when required; and we are not requesting Cosumnes Community Services District personnel to assist in the administration of our child's medication. Our child will need

to self-administer his/her emergency medication during program hours because he/she suffers from the following life-threatening condition: _____ (state nature of illness). Our child will need to take his/her medication _____ (# of times/day) with the following special instructions: _____ _____ _____.

**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 Tiny Tot Preschool s program.**

_____ _____ _____

Parent/Guardian Signature Date Daytime Phone

Emergency Contact: _____ Phone: _____