



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 to your child while attending camp. This form WILL NOT be accepted without a physician's signature.

****THIS FORM IS DUE 20 BUSINESS DAYS PRIOR TO THE START OF YOUR CHILD'S CAMP****

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.

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
(A stamp is acceptable if title is present)

Phone Number

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