



MEDICATION ASSISTANCE FORM

CHAMPS Charter High School of the Arts (CHAMPS) requires that students who need assistance taking medication during school hours or at school sponsored activities provide the following documents and supplies to the **Admissions Office** before the student can take medication during school hours/activities:

1. A completed Request for Assistance Concerning Student Medication and Assumption of Risk/Waiver/Release/Indemnity Form.
2. A written statement from the student's prescribing physician detailing the method, amount and schedule for the medication. (See the Written Statement of Prescribing Physician.)
3. The medication in its original, labeled container.
4. Any supplies or additional equipment needed to administer the medication.

Request and Consent for Assistance Concerning Student Medication and Assumption of Risk/Waiver/Release/Indemnity Form

Student's Name: _____

Name of Medication/Medical Procedure (Medication): _____

Prescribing Physician's Name: _____ Prescribing Physician's Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Request and Consent for Assistance Concerning Student Medication

I _____ (insert parent/guardian's name) and _____ (insert Student's name) hereby request and consent to assistance from CHAMPS, through its officials, employees, agents and volunteers to assist in the administration of the Medication(s) listed above. I understand that CHAMPS will not provide any assistance that is inconsistent with the prescribing physician's written statement concerning the Medication.

I agree that CHAMPS, including any official, employee, agent or volunteer may communicate directly with the Student, the Prescribing Physician and/or the pharmacy identified above, as may be necessary, regarding the Student and his/her Medication.

I agree to deliver a written statement from the Prescribing Physician, substantially in the same form as the Written Statement of Prescribing Physician attached hereto to the **Admissions Office** at least one (1) week prior to the commencement of the first date the Medication is to be administered during school hours or at a school sponsored activity, whenever possible. CHAMPS will not assist in the administration of any Medication unless and until it receives items 1-4 listed above.

I agree to immediately notify CHAMPS, including the **Admissions Office**, of any changes in the Student's prescription including changes in the medication, dosage, frequency of administration, or

reason for the administration. I understand that it is solely my responsibility to ensure Student has enough Medication and supplies at CHAMPS.

I understand that I may terminate my consent for assistance of CHAMPS in the administration of Medication by informing the **Admissions Office** in writing.

Assumption of Risk/Waiver/Release/Indemnity

In consideration for Student attending CHAMPS and the assistance of CHAMPS in the administration of Student's Medication, _____ (insert parent/guardian's name) and _____ (insert Student's name) hereby waive, release and discharge any and all claims for damages or personal injury, death, or property damage which they may have, or which may hereafter accrue to them, as a result of the assistance in the administration of the Medication.

This release is intended to discharge in advance CHAMPS and its officials, employees, agents and volunteers from any and all liability arising out of or connected in any way with the assistance in the administration of Student's Medication, even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above to the extent permitted by law.

I am aware that CHAMPS cannot provide assurances that CHAMPS staff and volunteers are specially qualified to provide assistance in the administration of the Medication, and no CHAMPS employees, agents or volunteers are licensed to administer medications.

Parent/Guardian and Student agree to indemnify and to hold the above persons or entities free and harmless from any loss, liability, damage, cost or expense which they may incur as the result of Student's death or any injury or property damage that Student may sustain as a result of the assistance in the administration of Student's Medication.

It is further agreed that this assumption of risk, waiver, release and indemnity is to be binding on Parent/Guardian, Student, and each of their heirs and assigns.

I HAVE CAREFULLY READ THIS REQUEST AND CONSENT FOR ASSISTANCE CONCERNING STUDENT MEDICATION AND ASSUMPTION OF RISK/WAIVER/RELEASE/INDEMNITY AND FULLY UNDERSTAND ITS CONTENTS. I AM FULLY AWARE OF ANY POTENTIAL DANGERS AND RISKS INHERENT IN AND INCIDENTAL TO THE ADMINISTRATION OF MEDICATION AND I AM FULLY AWARE OF THE EFFECT OF SIGNING THIS WRITTEN INSTRUMENT AND I SIGN IT OF MY FREE WILL.

PARENT/GUARDIAN CERTIFIES THAT HE/SHE HAS CUSTODY OR IS THE LEGAL GUARDIAN OF THE STUDENT BY COURT ORDER, AND SIGNS BELOW ON BEHALF OF HIMSELF/HERSELF AND MINOR STUDENT.

STUDENT MUST ALSO READ AND SIGN THIS AGREEMENT.

Parent/Guardian Signature: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian emergency contact information is as follows:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

CHAMPS must be notified immediately of any changes in the above emergency contact information.

Student Signature: _____

Written Statement of Prescribing Physician

Student's Name: _____

Date of Birth: _____ Telephone: _____ Drug Allergies: _____

Name of Medication/Medical Procedure: _____

Dates Medication/Medical Procedure is to be Administered: _____

Times Medication/Medical Procedure is to be Administered: _____

Physician's Requirements of Dosage/Method of Administration: _____

Other information relevant to administration of medication to Student or otherwise assisting in administration of medication to Student, including any precautions, possible side effects, interventions, or storage or handling requirements: _____

The authorized health care provider signing below certifies that s/he has prescribed the above described medication to the Student.

Physician's Signature: _____ Date: _____

Physician's Name (Printed): _____

Physician's Phone Number: _____

Physician's Address: _____