



**Health Program Medication Authorization**

Student's Name (First and Last) \_\_\_\_\_ Grade \_\_\_\_ Age \_\_\_\_ Program \_\_\_\_\_

**Physician Directions**

Medications to be given \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Time \_\_\_\_\_

Starting Date \_\_\_\_\_ Termination Date \_\_\_\_\_

Purpose of Medication \_\_\_\_\_

Possible side effects/observations to note \_\_\_\_\_

Physician requests comment from program? Yes \_\_\_\_\_ No \_\_\_\_\_

The medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.

Physician Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

I request the student about receive the medication as ordered by the physician while at Elkhorn Kids Campus. I understand it is my responsibility to furnish the medication in the original container or prescription bottle appropriately labeled by the pharmacy or physician stating name of medication, dosage, and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

**Complete this section ONLY if medication is PRN/as needed**

Medication should be provided when: \_\_\_\_\_

Notify if additional instructions: \_\_\_\_\_

I find the following unlicensed individual/s competent to provide medication stated above:

\_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Complete this section ONLY if medication is to be given by route OTHER THAN oral, inhalation, topical or instillation**

Written procedure (may be attached):

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I find the following unlicensed individual/s competent to provide medication stated above:

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I find the following unlicensed individual/s competent to assist in monitoring the previously stated medication: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Complete this section ONLY if participation in monitoring is necessary**

I request that the following observations be made and reported to me in the timelines stated:

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I find the following unlicensed individual/s competent to assist in monitoring the previously stated medication: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Release of Liability– Parents Please Read Carefully**

I give consent for the minor child listed in this form to participate in the Kids Campus childcare program as operated by the Elkhorn Public Schools Foundation. I agree to abide by any and all rules and policies of the Kids Campus program as outlined in the Annual Contract Services Agreement, the Student Registration form, the Family Handbook and the agreement.

I hereby agree to release from any and all legal liability and agree not to sue or make a claim against, and to indemnify and hold harmless the Kids Campus program and the Elkhorn Public Schools Foundation, its parents, officers, agents and employees (the Released Parties) for any and all claims for damage, injuries, death to said minor caused by or resulting from efforts to implement this and other associated medication plans.

If I am signing the Release of Liability on behalf of a minor, I represent that I am the parent and/or legal guardian of said minor. I accept responsibility for all said minor's medical expenses incurred in connection with the Kids Campus program. I agree to indemnify the Released Parties for any and all claims whatsoever brought by the said minor, and I agree to indemnify the Released Parties from and against any and all claims whatsoever brought by a third party arising in connection with said minor.

I have read and agree to all the above policies as outlined. I understand that failure to follow any Kids Campus or state of Nebraska policies may lead to denial of minor's participation in the Program. I am of authority to enter into this agreement on behalf of the said child and myself; I agree to be bound by its terms.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_