Request For Assistance Concerning Learner Medications

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN: (return completed form to the iLEAD school/learning studio)

Date: _____

Learner Name ("Learner"): _____

Medication Name ("Medication"): _____

Prescribing Doctor's Name: _____

Prescribing Doctor's Phone: _____

Pharmacy Name: _____

Pharmacy Phone: _____

1. Request and Consent for Assistance Concerning Learner Medication.

The undersigned Parent/Legal Guardian and Learner hereby request and consent to the following assistance from iLEAD Schools/Learning Studios, through its officials, employees, agents and volunteers including chaperones (all of whom are collectively referred to as "School/Learning Studio" in this form), related to Learner's Medication during the activity described as: _____

_____

Activity(s) scheduled to take place from: _____/_____/_____ to: _____/_____/_____

I understand that I must specifically describe any requested assistance from the School/Learning Studio in the space provided above, including any storage needs, and the School/Learning Studio will rely on the information I am providing on this form. The School/Learning Studio will not provide any assistance that is inconsistent with the Prescribing Doctor's written statement concerning the Medication. In the event of a material or significant deviation from the Prescribing Doctor's written statement, the School/Learning Studio shall notify the Learner's emergency contact, Learner's Prescribing Doctor and the School/Learning Studio Director as quickly as possible upon discovery. I agree that the School/Learning Studio, including any official, employee, agent, volunteer or chaperon, and the individual(s) designated below, may communicate directly with the Learner's Prescribing Doctor and/or the pharmacy identified above, as may be necessary, regarding the Learner and his/her Medication including the Prescribing Doctor's written statement. I agree to deliver a written statement from the Prescribing Doctor to the School/Learning Studio Director no later than one (1) week prior to the commencement of the Activity. A copy of the form is attached. I agree to immediately notify the School/Learning Studio, including the School/Learning Studio Director, of any changes in the Learner's prescription including changes in the medication, dosage, frequency of administration, or reason for the administration. I agree to provide any necessary medication, supplies, and equipment to the School/Learning Studio Director no later than five (5) School/Learning Studio days prior to the commencement of the Activity. I understand that I may terminate my consent for assistance of the School/Learning Studio in the administration of medication by informing the School/Learning Studio Director in writing.

2. Designated Non-School/Learning Studio Personnel to Administer Medication.

I further understand that no School/learning studio officials, employees, agents, employees or volunteers including chaperones attending the Activity are licensed to administer medications, and the School/Learning Studio therefore will not perform injections. In all circumstances, it is Parent/Legal Guardian's sole responsibility, and not the School/Learning Studio's, to determine whether Parent/Legal Guardian's designated individual is qualified to administer Learner's Medication.

I designate the following individual(s) to administer Learner's Medication:

Designated Individual's Name: _____

Phone: _____

Address: _____

State any limits on individual's authority: _____

I understand the designated individual must also agree to administer Learner's medications, and that the School/Learning Studio shall have no responsibility to administer medications if the designated individual is unavailable or does not agree to do so. I agree that the School/Learning Studio and Learner's Prescribing Doctor and Pharmacy may share information related to the Learner and his/her Medication with the designated individual, including providing a copy of this request, Prescribing Doctor's written statement and medication log.

3. Assumption of Risk, Release from Liability, Defense and Indemnification of School/learning studio, School/learning studio Personnel, Chaperones, and Designated Individual.

In consideration for Learner's participation in the Activity and the assistance of the School/learning studio in the administration of Learner's Medication, Parent/Legal Guardian and Learner hereby voluntarily agree to release, discharge, waive and relinquish any and all liability, claims or causes of action for personal injury, wrongful death, damages which they may have, or which may hereafter accrue to them, as a result of the administration or assistance in the administration of the Medication against iLEAD Schools, its governing Board, or any of its officers, employees, volunteers, including chaperones, agents, parent corporations, subsidiaries and affiliates, and the individual designated above to administer the Learner's Medication. I do so for myself and my heirs, executors, administrators and assigns, and even if such claims or causes of action shall arise by the negligence or carelessness of the School/Learning Studio or otherwise. Further, I, for myself, my heirs, executors, administrators or assigns, agree to defend and indemnify the School/Learning Studio in the event that any claim for personal injury, wrongful death, damages or property damage in any way relating to the administration or assistance in the administration of Medication to the Learner. It is understood that the administration of medication involves an element of risk and danger of personal injury, and that medical services may not be available or immediately available. Knowing those risks, Parent/Legal Guardian and Learner hereby assume those risks.

I HAVE CAREFULLY READ THIS AGREEMENT, INCLUDING THE ASSUMPTION OF RISK, WAIVER, RELEASE AND INDEMNITY, AND FULLY UNDERSTAND ITS CONTENTS. LEARNER MUST ALSO READ AND SIGN THIS AGREEMENT.

Parent/Legal Guardian Signature: _____ Parent/Legal Guardian Name (Printed): _____

Learner Signature: _____ Learner Name (Printed): _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

The School/learning studio must be notified immediately of any changes in the above emergency contact information.

ATTACHMENT

Written Statement of Prescribing Doctor

Student Name:_____

Medication Name:_____

Dosage:_____

Method of Administration:_____

Dates Medication is to be Administered:_____

Times Medication is to be Administered:_____

Other information relevant to administration of medication to Student or otherwise assisting in administration of medication to learner, including any storage or handling requirements:

_____

_____

_____

The authorized health care provider signing below certifies that he/she has prescribed the above-described medication to the learner.

Prescribing Doctor's Signature:_____

Prescribing Doctor's Name (Printed):_____

Prescribing Doctor's Phone Number:_____

Prescribing Doctor's Address:_____