MEDICATION/MEDICAL EQUIPMENT ACCOMMODATION REQUEST AND AUTHORIZATION

This form must be completed by a parent or guardian and signed by a licensed health professional at least two weeks prior to program start date. The request will be considered by the Museum Director of Education and is subject to approval prior to your child attending the program. If the request is denied, you will be notified and program tuition will be refunded in full if you choose to withdraw your child from the program.

___________________________________ ___________________ ___ Photo of Child attached (required)
Child's Name Birthdate

Name of program(s): ____

Medication must be supplied to HOCM in the original container, and the written authorization must match exactly the information on the container.

The following medications may or will need to be dispensed/administered during program hours:

#1 Name of Medication: ____________________________ Dosage: ______________________
Method of Admin/Time of Day: ____________________________/_____________________________
____
If PRN specify the length of time between doses: ____
Reason for medication to be taken during program hours: ___________________________________
____
Possible side effects of medication: ____
____
Emergency procedures in case of serious side effects from medication:_________________________
____

My child will carry this medication on person during the program :____Yes ____No (stays w/teacher)
My child can self-administer this medication: ____Yes ____No
Prescribing Physician: ____

#2 Name of Medication: ____________________________ Dosage: ______________________
Method of Admin/Time of Day: ____________________________/_____________________________
____
If PRN specify the length of time between doses: ____
Reason for medication to be taken during program hours: ___________________________________
____
Possible side effects of medication: ____
____
Emergency procedures in case of serious side effects from medication:_________________________
____

My child will carry this medication on person during the program: ____Yes ____No (stays w/teacher)
My child can self-administer this medication: ____Yes ____No
Prescribing Physician: ____

I certify that I am the parent, legal guardian, or other person in legal control of the above named program participant. I request and authorize HOCM to dispense/administer the above identified medication to the above identified program participant from ___________________ to ___________________ in accordance with the prescription or instructions from a licensed health professional. I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed.

I release, absolve and waive any right to bring a claim, action suit, or other proceeding against the Hands On Children's Museum, the organizers and sponsors of the program, or instructors of the program for damages due to any injuries suffered as a result of dispensing or administration of the above medication.

____ ______________________________

Parent or Guardian signature Date

____ ______________________________

Name (please print) Phone

To be completed by licensed health professional:

I request and authorize the above named program participant be administered the above medication in accordance with the instructions indicated above. There exists a valid health reason which makes administration of the medication advisable during the program hours or during such time that the program participant is under the supervision of HOCM officials. Such medication may be administered by trained HOCM personnel or self-administered by child (if so indicated above). Trained staff will have attended CPR and First Aid training from the American Red Cross or equivalent.

____ ______________________________

Licensed health professional signature Date

____

Name (please print)

____ ______________________________

Address (please include city and zip code) Phone

____

HOCM Director of Education (or other Director) Signature

Accommodation Approved? _____Yes _____No