CITY OF GALT
MEDICATION WAIVER FOR SOAR PROGRAM

Student Name: _____

Address: _____

School: _____Grade:_____

Parent/Guardian Phone: Home: _____ Work: _____

Cell: _____

Emergency Contact: Name _____ Phone No. _____

Students, who have been prescribed medication by a physician to be taken during the SOAR program hours, whether of limited or permanent duration, may self-administer their medication when the student is under the City's care, custody, or control.

The City, and its employees, will **NOT** administer medication, assist with the administration of medication, or monitor the self-administration of medication by the student. The City assumes **no responsibility** for the self-administration of medication by students enrolled in the SOAR program.

Before medication may be self-administered by a student, this waiver must be executed by at least one parent/legal guardian.

All medication in the possession of a student for self-medication must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store.

PARENT/GUARDIAN WAIVER

I have read, understand, and agree to be bound by this Waiver. I am the parent or legal guardian of the student named above on this form. I and my student understand that the City and its employees will **NOT** administer medication, **NOT** assist with the administration of medication, and will **NOT** monitor the self-administration of medication by my student. I understand that the City will allow my student to self-administer medication listed below during SOAR program hours, as long as the medication is in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. The medication that my student may self-administer is the following:

Name of medication: _____

Description of medication (pill, tablet, color, etc.): _____

_____

Prescription medication: YES_____ NO _____

Frequency / time of self-medication:_____

I understand and agree that the City assumes **no responsibility** for the self-administration of medication by my student. I represent that my student is fully capable of self-administering the medication identified above, without my assistance or supervision, or the assistance or supervision of any other person.

I assume full responsibility for my student relating to his/her conduct in self-administering medication, or failing to self-administer medication. Further I waive and release the City and/or its employees from any and all claims relating to my student self-administering medication, or failing to self-administer medication.

_____ _____

Date Signature Parent/Guardian

_____

Printed Name Parent/Guardian