CHILDREN ACADEMY

Authorization for Administering Prescription Medical Treatment, Waiver, and Consent

Name of Child:_____ Date: _____

Policy Statement: It is Learning Edge Academy's policy that all medications/treatments should only be given in a child care setting when truly necessary. It is safest and best for children to receive these at home. The Company administers prescription and non-prescription treatments voluntarily as a service to our parents and may be discontinued at any time, without notice.

I certify that I have read and that I understand and acknowledge the following:

1) I am the custodial parent/legal guardian primarily responsible for the medical care of the above listed child ("My Child"), and I am the age of legal majority or an emancipated minor in the state in which I sign this.

2) I accept full responsibility for this and all prescription medical treatment ("PMT") which I provide to the Company for administering to My Child, and I waive all actions, claims, and demands now known or later discovered against the Company, its employees, affiliates, and insurance providers and hereby forever release them from liability for injuries, illness, and any other adverse reaction (including those resulting from the Company's refusal to administer PMT) resulting from its use of the PMT.

3) I have previously administered the below PMT to My Child in the dosage and manner which I instruct below, without adverse or allergic reaction of any kind. I instruct the Company to administer the below to My Child according to my complete and accurate written instruction. The Company refuses to administer the PMT if my instructions are not clear, I am requesting for medication to be administered more than twice a day, or if they are inconsistent with its label, recommended usage, Physician's instruction, or dosage. The Company will refuse to administer the PMT if it is not in the original container, labeled with the original unaltered label.

4) The Company has the right to discontinue this PMT if (a) an adverse reaction results, (b) the PMT form expires, (c) the child is ill or injured, (d) the PMT can be administered before or after child care, (e) if this Authorization for Administering Prescription Medical Treatment form is incomplete, or (f) for any other reason if, in the Company's sole opinion, it is in the best interest of the child.

5) This authorization must be renewed after seven (7) ending Friday, but the waiver and consent remains in full force and effect. This Authorization and Waiver form may not be altered. (PMT are recognized by Learning Edge Academy Inc. as all over-the-counter medications, prescription medications, oral, nebulizer, or topical medications). PRNs are not accepted for any medications. A Doctor's authorization is required in addition to signing this waiver. When medication needs to be taken home at the end of the day or end of the dose, I am responsible for remembering to take it home. I release the company of any liabilities resulting from my forgetting to pick up my medication.

6) Since Learning Edge Academy does not have medical staff on site, we are not responsible for anything that may occur as a result of the medication. An administrator will notify the parent in the event that we forget to administer the medication.

7) Please note that on field trips, any medication requiring electricity may not be able to be administered.

8) In the event that Learning Edge Academy is unable to administer medication because a component is missing (ie: medication, part of machine, measuring device, or any other component), Learning Edge Academy will not notify the parent and will not be liable for anything that may occur as a result of not administering the medication.

CHILD AND MEDICAL INFORMATION (to be completed by parent)

_____

Child's Name **Parent/Guardian Name**

_____

Prescription Medication **Prescription Number** **Dates to be Given (form expires on Friday)** **Times to be Given (10:00am AND/OR 2:30pm)**

_____

Amount to be Given / Directions / Method **Reason for Medication**

_____

Physician's Name and Phone Number **Pharmacy Name and Phone Number**

_____

Parent/Guardian Signature **Date**

MEDICATION ADMINISTRATION INFORMATION (to be completed by Center employee)

Medication	Date	Time	Method	Amount	Signature of Person Dispensing Medication	Comments / Adverse Effects