



CONSENT AND DIRECTIONS TO STAFF  
FOR THE ADMINISTRATION OF MEDICINES

Participant's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Program \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_  
\_\_\_\_\_

Allergies (include food restrictions, etc. and note severity of allergy or reaction):  
\_\_\_\_\_  
\_\_\_\_\_

Allergy Signs or Symptoms to look for:  
\_\_\_\_\_  
\_\_\_\_\_

Asthmatic: \_\_\_ Yes \_\_\_ No If yes, comments: \_\_\_\_\_

**INSTRUCTIONS:** All medications, prescription and over the counter, must be provided to the City of Pleasanton's Community Services Department staff in the original packaging, with the Participant's full name written on the container. Remember to provide medication cups, spoons or other instruments for the medication's administration.

Participants are responsible for arriving at the program with all necessary medications, supplies, pumps, back-up medications and any other necessary equipment. It is the responsibility of the Participant to take home any unused medications or equipment. Any medication or equipment not removed by Participant at the end of the program will be disposed of.

Participant (and/or Guardian) must provide the name of each medication, dosage, and frequency (when and how often) below in the INSTRUCTION section. If additional instructions are required, please attach another sheet.

**INSTRUCTIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Participant/Guardian initials: \_\_\_\_\_



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Participants are responsible for providing all necessary information above regarding medical conditions, allergies, dietary restrictions, food allergies or special diet considerations to City staff. If more room is needed, please attach additional sheets.

**Participants are required to self administer all medications. The City of Pleasanton's staff will, however, administer an Epi-Pen to Participants in the rare circumstance where a Participant is unable to self-administer an Epi-Pen and treatment is needed, City staff will administer the Epi-Pen.** In the event an Epi-Pen is self-administered by the Participant or is administered by staff, City staff will call 911 because the beneficial effects of the Epi-Pen may be limited and the allergic reaction may reoccur as the effects of the Epi-Pen wears off.

**Participants are required to self administer all medications. City staff will, however, assist the Participant to self-administer his/her medication if the Participant or his/her Guardian requests assistance or staff observes that the Participant needs assistance.** Please write specific step-by-step instructions for staff to follow in the event the Participant has an allergic reaction or displays symptoms of a medical condition and needs assistance from staff for the Participant to be able to self-administer his/her medication. Participant or his/her Guardian must confirm these steps with the Participant's physician or health care provider. **By providing these instructions, Participant (and his/her Guardian) agree and consent to allow City staff to assist Participant with self-administration if assistance is requested by Participant or his/her Guardian or staff observes that the Participant needs assistance.**

Medical monitoring of blood sugar levels must be done by Participant (or his/her Guardian) prior to attending the program each day to ensure that the Participant is within his/her target range. Staff **will not** be responsible for identifying symptoms of hyperglycemia or hypoglycemia, but can assist the participant in checking blood sugar levels if proper training is provided to staff by parents or guardians.

### **AUTHORIZATION, WAIVER AND RELEASE**

I Participant (and his/her Guardian) authorize the City of Pleasanton through its Community Services employees ("City staff") to assist with the self-administration of Epi-Pens or administer an Epi-Pen in the rare circumstance where a Participant is unable to self-administer an Epi-Pen and treatment is needed. I acknowledge the assistance in administration or administration of the Epi-Pen or other medication to the Participant will be performed by City staff who are not nurses or medical professionals, and I specifically consent to such practice.

I Participant (and his/her Guardian) further authorize City staff to assist Participant with the self-administration of his/her medication if the Participant (or his/her Guardian) requests assistance or staff observes that the Participant needs assistance. Assistance with medications includes but is not limited to injections or medications (whether over-the-counter or prescription) or any other steps or treatments that may or may not be described on this form to treat any illness, medical condition, allergic reaction, injury, or emergency that the Participant may experience.

I Participant (and his/ her Guardian) recognize and acknowledge that there are certain risks of injury in connection with administration of medication. Such risks include, but are not limited to, failing to



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properly administer the medication, failing to observe side effects, failing to assess and recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

I Participant (and his/her Guardian) also give permission to City staff to contact emergency services (call 911) or obtain emergency medical treatment if necessary and agree to be wholly responsible for payment of any and all medical emergency services rendered to the Participant.

**The Participant (and his/her Guardian) hereby hold harmless and waive any claim on behalf of the Participant, the Participant's heirs, the Guardian, and Participant's executors, assigns or representatives against the City of Pleasanton, its officials, officers, employees, agents, or volunteers, from any and all claims for damages arising out of or in any way connected to the self-administration, assist-in-administration, failure to administer, or attempt to administer any medication to the Participant.**

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Participant's Parent/Guardian: \_\_\_\_\_

Signature of Participant's Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_