CHARLES M. SCHULZ MUSEUM AND RESEARCH CENTER

AUTHORIZATION FOR ADMINISTERING MEDICATIONS

TO BE COMPLETED BY THE CHILD'S DOCTOR, AND PARENT(S)/GUARDIAN(S)

Date: _____

Dear Doctor:

Your patient, _____, is enrolled/enrolling in the Charles M. Schulz Museum and Research Center (Museum) for classes, workshops, or other services, and the Museum has been requested to administer medications.

Please complete this authorization/instruction record. This record will remain in the child's file at the Museum.

Child's Name:_____Child's Birth Date:_____

Medications (describe the medications):

Amount, frequency and method of administration:

Special instructions regarding administration:

Instructions regarding care, handling, and storage of medications or other materials:

Please answer the following questions:

1. Can the child administer the medications himself or herself? __Yes

__No

2. Can the parent(s)/guardian(s) administer the medications? __Yes

__No

3. Can Museum staff administer the medications? __Yes

__No

4. Can someone else administer the medications? __Yes

__No

5. Is any training, experience, or skill needed to administer the medications or to otherwise carry out the functions outlined in this Authorization?

__Yes

__No

6. If your answer to number 5 above is 'Yes', please describe all training, experience or skill needed, and please attach or describe your recommendations as to how the training should be accomplished, and how the experience or skill requirements should be satisfied.

Recreational Activities:

1. The child may participate in recreational activities [ ] Yes [ ] No

2. Activity restrictions: [ ] None [ ] Some Restrictions. Explain:

3. Restrictions on exposure to materials (paint, glue, dust, other materials): [ ] None

   [ ] Some Restrictions. Explain:

Diet Restrictions:

1. Specify any diet restrictions or considerations.

Other:

1. Specify any other information that may be pertinent, including allergies or other conditions.

Child's Physician

Name:_____

Address: _____

_____

Telephone No.:_____

Emergency Contact No.:_____

Signature:_____ Date:_____

TO BE FILLED OUT BY PARENT(S) AND/OR GUARDIAN(S)

Name: _____

Address:_____

Telephone No.: _____

Emergency Contact No.: _____

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

Indicate the person(s) who is/are authorized to administer medications.

Check all that apply:

___ Museum Personnel (employees or independent contractors)

___ Parent(s) or Guardian(s)

Name(s) of parent(s) or Guardians authorized:

___ Child

(If checked, this means that the child can administer the medications himself or herself)

___ Siblings

Name(s) of sibling(s) authorized: _____

___ Other Authorized persons:

Name, address and contact information:_____

Name, address and contact information:_____

Name, address and contact information:_____

Name, address and contact information:_____

BY SIGNING THIS FORM, I/WE AUTHORIZE THE CHARLES M. SCHULZ MUSEUM AND RESEARCH CENTER TO FOLLOW THE ABOVE INSTRUCTIONS. I/WE AGREE TO UPDATE THIS FORM EVERY SIX (6) MONTHS, OR SOONER, IF THE CHILD'S NEEDS CHANGE. I/WE UNDERSTAND AND AGREE THAT IT IS OUR RESPONSIBILITY TO PROVIDE FULL AND COMPLETE INFORMATION TO THE MUSEUM, AND TO ENSURE THAT ALL MEDICATION AND OTHER MATERIAL OR EQUIPMENT IS PROPERLY LABELED AND PROVIDED. I AUTHORIZE THE MUSEUM TO CALL EMERGENCY RESPONDERS, INCLUDING '911', IN THE MUSEUM'S DISCRETION.

Signature:_____
Date:_____
Emergency Contact Information:_____

[Parent/Guardian]

Signature:_____
Date:_____
Emergency Contact Information:_____

[Parent/Guardian]

Comment(s):

_____

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