UPWARD BOUND PROGRAMS, CAL POLY POMONA
3801 W Temple Ave, Bldg 13D Pomona CA 91768 I 909 869 3231

Request for the *Administration of Medication* **Upward Bound Programs Summer 2024**

To be completed by Parent/Guardian			
Last Name of Student:	**First name of Student:**	**Sex:**	**Date of Birth:**

NOTE: All medications must be prescribed, ***including*** over-the-counter medications. Medications must be in the original container and the label must include the student's name, name of the medication, dosage, method of administration, time schedule and name of Physician.

I request that designated Upward Bound Programs' staff assist my student (named above) in taking the prescribed medication (including prescribed over-the-counter medication). I agree to and do hereby hold ***the Cal Poly Pomona Foundation, Inc. & the Cal Poly Pomona, Upward Bound (UB) Programs*** and its employees harmless of any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of the acts or omissions with respect to this medication. I understand that my student may not have nor take medication during the UB Summer Program unless all requirements are met. **I hereby give consent for *the Cal Poly Pomona, Upward Bound Programs' staff* to communicate with my student's Physician and counsel program staff as needed with regard to this medication.** I will ***immediately*** notify Upward Bound Programs if there are any changes in medications my student is taking while participating in the 2023 Upward Bound Summer Program including any summer trips.

Parent/Guardian Signature:	**Date:**	**Telephone:**

Physician's Order: (To be completed by a Licensed Physician only.) The student named above is under my care. It is necessary for this student to receive the following prescribed medication as instructed below.

Name of Medication:	**Reason/Purpose for Medication:**	**Dosage:**
Time/Frequency to be Taken:	**If "as needed" describe indications and sequence orders:**	
Precautions/Special Instructions:	**Side Effects:**	
Storage and Handling:		
Date of Rx:	**Length of time this medication to be taken:**	
Physician Name:	**Physician Signature:**	
Address:	**Telephone:**	**Date:**

UPWARD BOUND PROGRAMS, CAL POLY POMONA
3801 W Temple Ave, Bldg 13D Pomona CA 91768 I 909 869 3231

Petición Para la *Administración de Medicamentos* **Programas Upward Bound Verano 2024**

Debe ser completado por Padre/Guardián

Apellido del Estudiante:	**Nombre del Estudiante:**	**Sexo:**	**Fecha de Nacimiento:**

ATENCIÓN: Todos los medicamentos deben ser prescritos, incluyendo auto medicamentos. Medicamentos deben estar en su contenedor original y la etiqueta debe incluir el nombre del estudiante, nombre del medicamento, dosis, método de administración, horario, y nombre del doctor.

Yo solicito que el personal asignado de los Programas Upward Bound asistan a mi estudiante en tomar el medicamento prescrito (incluyendo auto medicamentos). Yo estoy de acuerdo, y por este medio libero ***a Cal Poly Pomona Foundation, Inc., & los Programas Upward Bound de Cal Poly Pomona*** y sus empleados de culpa de cualquier reclamación, demanda, causas de acción, responsabilidad o pérdida de cualquier tipo, debido a causas derivas u omisión con respecto a este medicamento. Yo entiendo que puede que mi estudiante no tenga ni tome medicamento durante el Programa de UB de verano al menos que todos los requisitos se cumplan. Por lo presente doy consentimiento ***al personal de los Programas Upward Bound de Cal Poly Pomona*** **de comunicarse con el medico de mi estudiante y el personal de consejo del programa según sea necesario en cuestión de este medicamento.** Yo notificare **inmediatamente** a los Programas Upward Bound si hubiese algún cambio en medicamentos que mi estudiante este tomando mientras participe en el Programa de Verano de Upward Bound 2023 incluyendo cualquier viaje de verano.

Firma de Padre/Guardián:	**Fecha:**	**Teléfono:**

Physician's Order: (To be completed by a Licensed Physician only.) The student named above is under my care. It is necessary for this student to receive the following prescribed medication as instructed below.

Name of Medication:	**Reason/Purpose for Medication:**	**Dosage:**

Time/Frequency to be Taken:	**If "as needed" describe indications and sequence orders:**

Precautions/Special Instructions:	**Side Effects:**

Storage and Handling:

Date of Rx:	**Length of time this medication to be taken:**

Physician Name:	**Physician Signature:**	
Address:	**Telephone:**	**Date:**