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

Request for *Self-Administration of Medication*
INHALERS/EPI-PENS

Upward Bound Programs
Summer 2024

Student Information

Last Name of Student:	First Name of Student:	Sex:	Date of Birth:

Parent/Guardian Information:

- I request that Upward Bound (UB) permits my student to carry and self-administer the medication indicated below for the duration of the 2024 Upward Bound Summer Program and any summer trips as prescribed by his/her physician
- I give authorization to Upward Bound Programs' staff to consult with my student's physician listed below regarding any questions that may arise with regard to the medication
- I release the following parties from all liability if my self-administering student suffers an adverse reaction as a result of the self-administering medication
  - the State of California, the Trustees of the California State University, California State Polytechnic University, Pomona, Cal Poly Pomona Foundation, Inc. and the Cal Poly Pomona Upward Bound Programs, and their employees
- I am also aware that my student may be subject to disciplinary action if the student uses the medication in a manner other than as prescribed

Parent/Guardian Name:	Parent/Guardian Signature:	Date:

Health Care Provider Information:

The student listed above is authorized to carry and self-administer the prescribed medication specified below.
(Please check the appropriate box. Use one form for each medication prescribed.)

❑ Inhaled asthma medication ❑ Auto-injectable epinephrine

Name of Medication:	Reason/Purpose for Medication:

Dosage:	Time(s) to be Taken:

Length of time to be taken during Summer 2024:	Date Prescribed:

Precautions/Special Instructions:	Side Effects:

Physician Name:	Physician Signature:

Address:	Telephone:	Date:

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Petición para *Autoadministración De Medicamentos*
INHALADORES/EPI-PENS

Programas Upward Bound
Verano 2024

Información de Estudiante

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

Información de Padre/Guardián:

- Yo solicito que Upward Bound permita a mi estudiante cargar y auto administrar el medicamento indicado abajo por la duración del Programa de Upward Bound 2024 y cualquier viaje de verano
- Yo doy autorización que el personal de los Programas Upward Bound consulte con el médico de mi estudiante, mencionado abajo, con respecto a cualquier pregunta que pueda surgir en cuestión del medicamento
- Yo indemnizo a las siguientes partes interesadas de toda responsabilidad si mi estudiante, al auto-administrarse, sufre una reacción adversa como resultado de autoadministración de medicamentos
  - el Estado de California, los fideicomisarios de la Universidad Estatal de California, Universidad Estatal de California Politécnica, Pomona Fundación Inc. de Cal Poly Pomona y los Programas de Upward Bound, y sus empleados
- Yo también estoy consiente que mi estudiante puede estar sujeto a acción disciplinaria si usa el medicamento en otra manera que la prescrita

Nombre de Padre/Guardián:	Firma de Padre/Guardián:	Fecha:

Health Care Provider Information:

The student listed above is authorized to carry and self-administer the prescribed medication specified below.
(Please check the appropriate box. Use one form for each medication prescribed.)

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Physician Name:	Physician Signature:

Address:	Telephone:	Date: