



Name of Program Attending: \_\_\_\_\_

**South Mountain YMCA  
Permission to Administer Medication**

*(Please use one form per medication and return to program site or fax to 973.762.2064)*

**The following information is to be completed.**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Wt.: \_\_\_\_\_

Medication: \_\_\_\_\_ Allergies: \_\_\_\_\_  
*Include food and/or medication allergies*

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time of day medication is to be given: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Special instructions: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
PLEASE PRINT

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**The following is to be completed by the parent or legal guardian:**

I hereby give permission for my child, \_\_\_\_\_,  
to receive the above medication, according to the listed directions and precautions, from  
the Director or designee. I confirm that I have given at least one dose of the medication  
without any evidence of side effects or adverse reactions. I understand that it is my  
responsibility to provide the medication in its original container and labeled with my  
child's full name and dosage. I am also to supply the appropriate measuring device  
needed to give an accurate dose of the medicine.

I usually do the following to make giving medication to my child easier:

\_\_\_\_\_

Amount of medication brought to YMCA: \_\_\_\_\_

**I authorize the Director or their designee to contact the pharmacist or Health  
Care Provider for more information about this drug, if necessary. I also  
authorize the Director or their designee to contact the health care provider  
regarding my child's health, if necessary**

\_\_\_\_\_  
*Signature of parent or legal guardian*

\_\_\_\_\_  
*Date*