

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*



***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 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.**

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

\_\_\_\_\_  
\_\_\_\_\_

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

**X** \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
*Signature of parent or legal guardian* *Date*

**After typing in all information, please print form, sign & date, and return to South Mountain YMCA**