Attach Child Photo

(if parent provided)

PARENT AUTHORIZATION FOR MEDICATION FORM
***one form is required for each medication**

Name of Child: ___________________________________ DOB: _________ Weight: ______

Medication Type: ☐ Prescription Medication ☐ Non-Prescription Medication

Medication: ________________________ Prescription #: ______________ Dosage: ____________________

Time(s) of Day Medication is to be Given: ☐ Lunch ☐ Other: ____________

When was last dose given to child: ____________________

Reason for Medication: ____

Special Instructions: ____

Possible Side Effects: ____

Continue Medication Until (date): _________________

Doctor Name _____________________________________ Doctor's phone # ________________________

Parent's Primary Phone _______________________ Parent's Secondary Phone ______________________

I GIVE PERMISSION FOR YMCA OF METROPOLITAN DALLAS TO ADMINISTER THE ABOVE REFERENCED MEDICATION ACCORDING TO THE INSTRUCTIONS ABOVE TO MY CHILD, ____ WHILE IN THE CARE OF THE YMCA, AS ORDERED BY MY HEALTHCARE PROVIDER.

Parent/Guardian Name: ______________________________ Signature: __________________________ Date: ________

*****This Section Completed by YMCA Health Officer*****
RECEIVING MEDICATION CHECKLIST

Prescription Medication

☐ Parent Permission Received (this form)
☐ Original prescription label is readable
☐ Name and strength of medication on label
☐ Medication is not expired
☐ Name of child matches intended recipient
☐ Health care provider name/contact on container
☐ Dispense instructions
☐ Storage instructions
☐ Child medication log set up

____
Health Officer Signature

Non-Prescription Medication

☐ Parent Permission Received (this form)
☐ Original manufacturer label is readable
☐ Name and strength of medication on label
☐ Medication is not expired
☐ Storage instructions
☐ Health care provider written note is provided
☐ Dispense instructions
☐ Child medication log set up

____
Health Officer Signature

*****This Section Completed by YMCA Health Officer*****
DISPOSITION OF LEFT-OVER MEDICATION VERIFICATION

☐ Thrown Away Date: ______________ ☐ Thrown Away Date:

____ ____
Health Officer Signature Witness Name/Signature