Medication Form

Please complete one form per medication to be administered.

Please select program: ☐ Before & After School (school name: _____) ☐ Camp

Student's Name _____ Birthday _____

Name of Medication _____Expiration Date_____

(Medication must match name on prescription bottle)

Reason for medication_____

Route of administration (oral, eye, nose, or throat drops; topical); _____

Dosage _____ ☐ Daily ☐ As Needed

(If non-prescription medication, dosage cannot exceed recommended age allowances as stated on container)

Special Instructions _____

How many times per day _____ Time of Day _____

Start Date _____ End Date _____

Name of prescribing physician _____Phone Number _____

Pharmacy _____Phone Number _____

Please list any allergies to other medications: _____

_____

MEDICAL RELEASE: I hereby give my permission for the YMCA to administer the above medication to my child as directed.

Parent / Guardian Signature _____Date_____

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER.

Review of Medication:

Initials:										
Date:										

Medication returned to: _____Date: _____ Staff: _____