Sussex County YMCA SCHOOL AGE CHILD CARE
PERMISSION TO GIVE MEDICATION

The following information is to be completed by the child's Health Care Provider

School: ____________________ Child's Name: ____________________

DOB _________ Wt. ______

Medication: ___________________________

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

____________________________________ __________________
Signature of Health Care Provider *Date*

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 Child Care Director or the Child Care Director 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. 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.

Amount of medication brought to YMCA: ______________

____________________________________ ______________
Signature of parent or legal guardian *Date*

Date & amount of medication returned to Parent ________________________________

________________________________ ____________________________
Signature of Director/ Director Designee *Signature of Parent/ Legal Guardian*