



**West Essex YMCA
Permission to Give Medication**

(Please use one form per medication)

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

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

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 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.

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

Amount of medication brought to YMCA: _____

Signature of parent or legal guardian *Date*

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Date & amount of medication returned to Parent _____

Signature of Director/ Director Designee

Signature of Parent/ Legal Guardian