Administration of Medication Form

I, _____________, the parent/guardian of _____________who is enrolled at the _______YMCA of Greater Louisville Summer Adventure Program, do hereby authorize the staff of the center to administer the following medication in the following dosage to my child. I release the YMCA of Greater Louisville from all liability for administering the stated medication in the stated dosage.

Medication: ____ ***Dosage:***_____________________

Condition of which prescribed:____

Possible side effects:____

Instruction for usage:____

To be filled out by Parent/Guardian

Date & Time Medication to be administered: ____/____ Parent Signature:______________

Staff Use Only

Staff administering medication: ________________________ Date:_________________

Staff verification witness: ___________________________ Date: _________________

Dosage Administered: ____

Please Check: _ Right Child _ Right Dosage _ Right Time _Right Medication _Right Route (By mouth, skin, etc.)

To be filled out by Parent/Guardian

Date & Time Medication to be administered: ____/____ Parent Signature:______________

Staff Use Only

Staff administering medication: ________________________ Date:_________________

Staff verification witness: ___________________________ Date: _________________

Dosage Administered: ____

Please Check: _ Right Child _ Right Dosage _ Right Time _Right Medication _Right Route (By mouth, skin, etc.)

To be filled out by Parent/Guardian

Date & Time Medication to be administered: ____/____ Parent Signature:______________

Staff Use Only

Staff administering medication: ________________________ Date:_________________

Staff verification witness: ___________________________ Date: _________________

Dosage Administered: ____

Please Check: _ Right Child _ Right Dosage _ Right Time _Right Medication _Right Route (By mouth, skin, etc.)

To be filled out by Parent/Guardian

Date & Time Medication to be administered: ____/____ Parent Signature:______________

Staff Use Only

Staff administering medication: ________________________ Date:_________________

Staff verification witness: ___________________________ Date: _________________

Dosage Administered: ____

Please Check: _ Right Child _ Right Dosage _ Right Time _Right Medication _Right Route (By mouth, skin, etc.)

To be filled out by Parent/Guardian

Date & Time Medication to be administered: ____/____ Parent Signature:______________

Staff Use Only

Staff administering medication: ________________________ Date:_________________

Staff verification witness: ___________________________ Date: _________________

Dosage Administered: ____

Please Check: _ Right Child _ Right Dosage _ Right Time _Right Medication _Right Route (By mouth, skin, etc.)

*Two staff must be present when administering any medication and ***BOTH*** staff must sign form.

*First staff will verify correct child, correct medicine, correct dosage, correct route, and correct time.

*Second staff will administer the medication (preferably the Program Director or Asst. Director).