



# Authorization for Medication

Child's Full Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescription Number: \_\_\_\_\_

Time Medication is to be given: \_\_\_\_\_  
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: \_\_\_\_\_

Dates to be given: \_\_\_\_\_  
(Not to exceed two weeks without a physician's statement)

The Following guidelines apply:

- Medication must be in the original prescription container with the child's name. Over the counter medication must be accompanied by doctor's instructions.
- The medication authorization form must be completed in full, by parent/guardian or doctor.
- Instructions must match container label and include starting and end dates.
- A new form must be completed for any changes and when log sheet is full.
- Parents/Guardians must be called after the use of inhalers

I have read, understood, and agree to follow the provisions above. I give permission for the Georgia Mountains YMCA staff to administer medication to my child as noted above.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

	Date	Time Given	Amount	Any Adverse reactions	Administered By
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____