MEDICATION AUTHORIZATION FORM

Complete this authorization form in full. Families registering more than one child will need to complete a **separate authorization form for each child.**

CHILD'S INFORMATION

First name: _____ Middle initial: _____ Last name: _____

Any specific activities to be encouraged or limited by physician's advice: _____

_____

Dietary restrictions/concerns: ◯ Doesn't eat dairy ◯ Doesn't eat eggs ◯ Picky eater ◯ Doesn't eat nuts ◯ Other

Please list any allergies the counselor should know of: _____

(Signature of parent)

IMMUNIZATIONS

This child is up to date on all immunizations required for school _____

If your child has NOT been fully immunized. Please sign the following statement: I understand and accept the risks to my child from

NOT being fully immunized _____ (signature of custodial parent/guardian)

Date of last Tetanus Booster shot: _____ (date required)

Date of last physical examination (must have been within the last 24 months): _____

Family medical/hospital insurance carrier: _____ Policy/group #: _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at the Y. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. Attached additional pages for more medications.

◯ Child takes routine medications ◯ Child takes routine medication during the school year

Please complete the following:

I hereby request that YMCA personnel administer the following medications:

This medication has been prescribed to my child by his/her physician as treatment for _____

This child takes the following medications: (Please attach additional pages for more medications)

Med #1: _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Possible side effects: _____

Food/other medication interactions: _____

Med #2: _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Possible side effects: _____

Food/other medication interactions: _____

Med #3: _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Possible side effects: _____

Food/other medication interactions: _____

◯ I have shown the following staff listed below how to administer an Epipen, inhaler, diabetic instruments, etc. if applicable.

_____

Last Name ◯ Day camp ◯ Sports and Specialty Date/Week# First Name Date

MEDICATION ADMINISTRATION

In order to ensure the safety of our campers, no medication shall be administered to a child in our care except as prescribed by a licensed physician and/or daily written request of the parent/guardian. The YMCA shall keep written record of the administration of each medication, including the time, date and dosage. Parents must complete this form and permission DAILY to administer medication–parent may not sign for days in advance.

Prescription medication must be in the original container with dosage amount and the child's name typed on it. Over the counter medication must be kept in the original packaging with appropriate dosage amount listed on the bottle/box. Parents must choose a time of administration for medication and may not state "as needed". Any additional dosages must be administered at the appropriate dosage amount written in the instructions on the label and at the appropriate time intervals. If a medicine or treatment is required only in certain circumstances, those symptoms or circumstances need to be typed up by the child's physician and placed with this form. No medication will be given to a child if the expiration date on the bottle has passed. The YMCA shall keep written record of the administration of each medication, including the time, date, and dosage.

Parents must train staff in the appropriate procedures for using Epipens, inhalers and diabetic instruments or other forms of medication that require special administration. Administration of certain medications/procedures may require approval through our insurance company. All Epipens, inhalers, diabetic instruments and medications must be kept in a locked box and with a child's personal belongings.

ALLERGIES (List all known)

Medication allergies

_____

_____

Describe reaction and management of the reaction.

_____

_____

Food allergies

_____

_____

_____

_____

Other allergies

_____

_____

_____

_____

I authorize the following to be administered (or their generic equivalent) as needed:

◯ Tylenol ◯ Chloraseptic ◯ Benadryl ◯ Cough drops ◯ Pepto Bismol

◯ Ibuprofen ◯ Neosporin ◯ Calamine lotion ◯ Comments: _____

GENERAL LIABILITY

I understand that the YMCA of Central Kentucky assumes no responsibility for injuries, which I or my child may sustain as a result of my child's physical condition or resulting from my or my child's participation in any activities, programs, exercise, or the use of any facility, equipment, or other activities organized or sponsored by the YMCA of Central Kentucky & Affiliates. I expressly acknowledge that I assume risk for any and all injuries and illnesses that may result. In consideration of the privilege of joining, or using the YMCA, I hereby voluntarily release and discharge its servants and employees from any and all claims for injury, death, loss or damage that I or my child may suffer. I understand the YMCA of Central Kentucky is NOT responsible for personal property lost or stolen while members and/or program participants are using YMCA facilities or on YMCA premises.

EMERGENCY AUTHORIZATION

I hereby give permission to the medical personnel selected by the YMCA staff to provide routine health care; to administer medications; to order X-rays; routine tests, treatment; to release any records for insurance purposes; and to provide or arrange necessary reliable transportation for myself or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the YMCA staff to secure and administer treatment including hospitalization for the named person above.

Signature _____ Date _____

Self/Parent/Guardian (circle appropriate title)

For reporting purposes, please consider answering the following. This information is confidential and is used for applying for grant opportunities.

Total number of people in the household _____

Annual household income:

◯ Less than $5,000 ◯ $5,000-$9,999 ◯ $10,000-$14,999 ◯ $15,000-$24,999 ◯ $25,000-$34,000

◯ $35,000-$49,999 ◯ $50,000-$74,999 ◯ $75,000-$99,000 ◯ $100,000 or more