

Madison Area YMCA /The F.M. Kirby Children's Center

MEDICATION PERMISSION FORM

Phone: 973-377-4945; FAX: 973-377-8534

Child's Name _____ Classroom _____

Medication will be given to a child only with a written request from the parent. Please use this form whenever your child requires medication while at the Center. Please use ONLY this form!

I hereby request and authorize the F.M. Kirby Children's Center to give my child _____ the following medication(s) in the dosages specified.

Reason for medication: _____ Adverse effect(s), if any: _____

(Please answer the following questions: Y=agree; N=no; NA=not applicable.)

PRESCRIPTION MEDICATION

____ Medication must be administered at home for a period of 24 hours if child has not been on this particular medication before; first dose must be given at home.

____ Medication in the original container labeled:

- ____ child's name,
- ____ name of medication,
- ____ date it was prescribed or updated,
- ____ directions for administration.
- ____ Parents instructions match prescription bottle.

SAMPLE MEDICATION

____ Note from physician with child's name, name of medication, dosage info, time to be given, how to mix medication, date and physician signature.

NON-PRESCRIPTION MEDICATION

- ____ Medication in the original container.
- ____ Dosage on parent permission form matches dosage on medication container.
- ____ Physician's authorization or note attached.
- ____ Over the counter medication will only be given for 3 days without a physician's note extending the time.

GENERAL POLICIES

- ____ No medication will be given out after 2:30 pm unless child has a long term, chronic medical condition.
- ____ No medication is to be put in a child's bottle, sippy cup or any food or drinks brought into the Center.
- ____ No child will be awakened from naps for medication without a doctor's note.
- ____ We reserve the right to limit amount of medications given at one time to a child.
- ____ We reserve the right to refuse to give any child medication.
- ____ School Age children are not allowed to keep any medication with them. All medication is to be kept in the Nurse's office.

<u>NAME OF MEDICATION</u>	<u>AMOUNT</u>	<u>CIRCLE TIME TO BE GIVEN</u>
_____	_____	11 12 1 2 AS NEEDED AFTER SCHOOL
_____	_____	11 12 1 2 AS NEEDED AFTER SCHOOL

This medication is to be continued through (date) _____.

Authorized Signature _____ Date _____

Staff person receiving medication and form _____.

***** ANY UNUSED MEDICATION WHICH HAS BEEN LEFT AT THE CENTER FOR MORE THAN TWO WEEKS WILL BE DISCARDED! PLEASE TAKE ANY UNUSED MEDICATION HOME. *****