YMCA OF SNOHOMISH COUNTY
MEDICATION PERMISSION FORM

CHILD'S FULL FIRST AND LAST NAMES				**DATE OF BIRTH**	**TODAY'S DATE**
				/ /	/ /
NAME OF MEDICATION			**CONDITION MEDICATION IS INTENDED TO TREAT**		
START DATE	**STOP DATE**	**TIME LAST GIVEN**	**FREQUENCY** (IE. EVERY 4 HOURS)	**TIME(S) TO BE GIVEN BY STAFF**	
/ /	/ /	☐ AM ☐ PM		☐ AM ☐ PM	☐ AM ☐ PM
DOSAGE TO GIVE (AMOUNT)		**PROCEDURE** (SPECIAL INSTRUCTIONS, IF APPLICABLE) - WRITE "NONE" IF NONE			
EXPECTED SIDE EFFECTS			**POTENTIAL ADVERSE REACTIONS**		
MEDICATION STORAGE			**INDICATE INSTRUCTIONS FOR PROPER STORAGE**		
HAS MEDICATION BEEN STORED PROPERLY? ☐ YES ☐ NO					
IS THIS A CONTROLLED SUBSTANCE?	☐ YES ☐ NO	**IF THIS MEDICATION IS A CONTROLLED SUBSTANCE, A MEDICATION COUNT VERIFICATION FORM (MCVF) IS ALSO REQUIRED & ONLY ONE WEEK'S SUPPLY MAY BE LEFT WITH STAFF.**			

I give permission for YMCA staff to administer this medication to my child as directed. I have provided instruction to the staff person in charge with procedures for administration of the medication and any specialized administration procedures (i.e. nebulizer, Epi-pen, or preference for swallowing pills).

I understand and agree that the YMCA staff cannot be held responsible for allergic reactions or other complications resulting from administration of the above medication given according to the provided instructions.

PARENT/GUARDIAN SIGNATURE ______________________________ **DATE** ____________

- ☐ Medication will only be given for the condition that it is intended to treat and as the physician and/or label instructions indicate.
- ☐ All medication must be in the original container and labeled with the child's first and last name.
- ☐ Label instructions must be clear and match the parent instructions provided to staff.
- ☐ Permission for non-prescription sunscreen and topical diapering medication is accepted for 180 days. All other over-the-counter medications are limited to a maximum of 30 days between start and stop dates. Permission for prescription medications is valid through the prescribed treatment period.
- ☐ Staff must administer medications according to the medication's prescription or manufacturer's label, as appropriate.
- ☐ For non-prescription medications that are to be to be administered differently than indicated on the manufacturer's label, legible written instructions from a physician must be included and followed for administration.
- ☐ Expired medication will not be accepted. Medication that expires after being received will not be administered.
- ☐ Any unused medication will be returned to the parent/guardian. When left at the center after disenrollment, the parent will be called to pick it up.
- ☐ Upon completion of the treatment period, this form will be kept on-site with the child's permanent file for a minimum of 12 months.
- ☐ All child records including this form are confidential and must be kept in such a manner.
- ☐ When a dosage is missed or otherwise not administered, the log will be completed as usual, however the "time" will indicate time noticed/decided not to give and the "dosage" column will indicate the reason the dose was not administered. The parent will be contacted upon discovery/decision and receive a written Communication Report.

STAFF RECORD (TO BE COMPLETED BY THE STAFF PERSON THAT IS ACCEPTING AND WILL BE ADMINISTERING THE MEDICATION)

I have received the above medication, confirmed that all criteria required by licensing regulations and YMCA expectations have been met and that all required procedures have been followed. The parent or guardian has provided instruction on properly administering the medication provided in accordance with the label. I also confirm that I have properly been trained in Medication Management.

I understand that I must document the administration of medication every time it occurs and give a written explanation on this form as to why I did not administer the medication when I should have.

ACCEPTING STAFF SIGNATURE ______________________________ **DATE** ____________

When the person accepting the medication cannot be the person to administer the medication due to staffing schedules, the accepting staff must relay all information regarding the medication to the staff person that will be administering the medication.

I have communicated with the accepting staff (or am the accepting staff), completely read this form and understand the instructions and expectations of administering this medication.

ADMINISTERING STAFF SIGNATURE ______________________________ **DATE** ____________

CHILD´S NAME	NAME OF MEDICATION	START DATE	STOP DATE
		/ /	/ /

DATE	TIME	MCVF	DOSE GIVEN (or reason not given)	ADMINISTERING STAFF NAME	STAFF SIGNATURE
/ /	☐ AM ☐ PM	☐ YES ☐ NO			
/ /	☐ AM ☐ PM	☐ YES ☐ NO			
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