OCEAN COUNTY YMCA

MEDICATION AUTHORIZATION FORM

Child's name_____

Phone Number_____

Child's Condition_____

TYPE OF MEDICATION (MUST BE IN ORIGINAL CONTAINTER)

1) MEDICATION_____

   DOSAGE_____ TIME TO BE ADMINISTERED_____

2) MEDICATION_____

   DOSAGE_____ TIME TO BE ADMINISTERED_____

3) FOR ADDITIONAL MEDICATION USE BACK OF FORM

I authorize the designated YMCA staff person to administer the above medication to my child

_____ _____

Signature of Parent/Guardian Date

FOR OFFICE USE ONLY

Date	Time	Staff