

**OCEAN COUNTY YMCA
MEDICATION AUTHORIZATION FORM**

CHILD'S NAME _____

PHONE NUMBER _____

CHILD'S CONDITION _____

TYPE OF MEDICATION (MUST BE IN ORIGINAL CONTAINER)

1) MEDICATION _____

DOSAGE _____ TIME TO BE ADMINISTERED _____

**IF EPI PEN FOR ALLERGY, THE DOCTORS CARE PLAN MUST BE ALSO ATTACHED. ALL
MEDICATION TO BE USED MUST ALSO ACCOMPANY THE EPIPEN (BENADRYL, ETC.)**

**INSTRUCTIONS ON DISPENSING
MEDICATION** _____

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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