MEDICATION CONSENT FORM

THIS FORM IS *REQUIRED ONLY* IF YOUR CHILD IS TAKING MEDICATION DURING THE ST. CLOUD YMCA SUMMER DAY CAMP PROGRAM.

Child's Name _____

Name of Medication: _____

Prescription: _____ Non-Prescription: _____

Dosage: _____

Date(s)/Days Medication to be Given: _____

Times Medication to be Given: _____

Reason for Medication (including allergies):

_____

Possible Side Effects (including allergies):

_____

_____

Name and Phone Number of Prescribing Physician: _____

_____

Directions for Storage: _____

I, _____, (parent/guardian) give permission to an authorized staff member(s) to administer medication to my child as indicated above.

I, _____, (parent/guardian) give permission for my child to carry his/her own inhaler in his/her bag and self administer as needed.

_____ _____

Signature of Parent/Guardian **(REQUIRED)** Date

_____ _____

Signature of Doctor (for medications and children carrying inhalers)- (**RECOMMENDED)** Date

Please return to Carolyne Anderson, Youth and Family Director, prior to first day of program.