FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Medication/Treatment Authorization Form

WHATCOM FAMILY YMCA

CHILD'S NAME _____ DOB _____ DATE _____

NAME of MEDICATION	DOSE:
TIME(S) TO GIVE MEDICINE:	
DATE TO START MEDICINE:	DATE TO END MEDICINE:
HOW IS THE MEDICINE GIVEN? ❑ BY MOUTH ❑ IN THE EAR ❑ IN THE EYE ❑ NEBULIZER ❑ ON THE SKIN ❑ OTHER	
KNOWN SIDE EFFECTS TO MEDICATION:	ADDITIONAL INSTRUCTIONS:
CHILD ALLERGIES:	

PERMISSION TO GIVE MEDICATION:

I hereby give permission to for the child care facility/licensee to give the medication as prescribed above.

PRESCRIBING HEALTH PROFESSIONAL'S NAME: _____

PARENT/GUARDIAN NAME (PRINT) _____

PARENT/GUARDIAN SIGNATURE _____ Date _____

ADDRESS _____

CELL PHONE _____ WORK PHONE _____

MEDICATION TRACKING SHEET (For Staff Use Only)

	DATE	TIME GIVEN		DOSAGE/AMOUNT	LICENSEE/ STAFF SIGNATURE	NOTES/ CONCERNS
MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
FRIDAY		AM	PM			
SATURDAY		AM	PM			
SUNDAY		AM	PM			
MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
FRIDAY		AM	PM			
SATURDAY		AM	PM			
SUNDAY		AM	PM			

CHILD'S NAME ______________________ DOB ____________ DATE __________

	DATE	TIME GIVEN		DOSAGE/AMOUNT	LICENSEE/ STAFF SIGNATURE	NOTES/ CONCERNS
MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
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SATURDAY		AM	PM			
SUNDAY		AM	PM			
MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
FRIDAY		AM	PM			
SATURDAY		AM	PM			
SUNDAY		AM	PM			
MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
FRIDAY		AM	PM			
SATURDAY		AM	PM			
SUNDAY		AM	PM			
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TUESDAY		AM	PM			
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MONDAY		AM	PM			
TUESDAY		AM	PM			
WEDNESDAY		AM	PM			
THURSDAY		AM	PM			
FRIDAY		AM	PM			
SATURDAY		AM	PM			
SUNDAY		AM	PM			

MEDICATION RETURNED TO PARENT/GUARDIAN

PARENT/GUARDIAN SIGNATURE: ______________________ DATE ______________

LICENSEE/STAFF SIGNATURE: ______________________