YMCA OF GREATER SEATTLE

Medical Authorization Form

MEDICAL AUTHORIZATION PLAN

Thank you for filling out this form to help us best serve your child in our Y programs. Please fill out the sections required for your child's medication needs.

All Medical Authorizations Requires a Physician's Signature (see page 2)

If you have any questions regarding this form, please reach out to our Youth Program Support team at **youthsupport@seattleymca.org**

Child's Name:	Date of Birth/Age:
Parent's/Guardian's Name	Phone Number:
Primary Health Care Provider	Phone Number:

List medications to be given at **scheduled times,** and dosage of medication to be given:

List medications to be given at **emergency,** and how medication is to be given:

Describe the symptoms that would trigger emergency medication:

List the steps and procedures the staff should perform during an emergency related to your child's accommodations:

SUGGESTED TRAINING FOR STAFF

List suggested special skills training/education for the program staff:

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Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Start Date:	Stop Date:
Times to be given: (*Can NOT be given "as needed")	Amount to be given:
Possible Side Effects:	Method of administration: ☐Oral ☐Topical ☐Other
☐ Above information consistent with label?	Method of Storage: Requires Refrigeration: ☐yes ☐no
Take emergency procedures when:	
Special Instructions:	

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician Signature Date

_____
Physician Phone Number

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Medication Record

(For Staff Use: must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

____ _____ ___ _____