



# CAMPANELLI YMCA

## MEDICATION DISPENSING AUTHORIZATION FORM

### KASPER 2020-2021 PROGRAM

\*\*\*This form MUST be completed for all medication or when medication changes.\*\*\*

#### BACKGROUND INFORMATION:

Participant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's/Guardian's Name(s): \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Program Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

#### MEDICATION INFORMATION:

Medication Name: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Quantity Supplied: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Dispensing and Storage Instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand that it is my responsibility to give the medication directly to program staff with full instructions in an unopened individual dosage containers, unopened non-prescription medication containers, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the YMCA if any changes in the dispensing of medication change.

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### RETURNING MEDICATION TO FAMILY:

Date Returned: \_\_\_\_\_ YMCA Staff Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_