

Authorization to Administer Medication

TWO RIVERS YMCA 2040 53rd Street

Moline, IL 61265 I give permission to Two Rivers YMCA staff to administer medication to my child. Child's Name Parent's Signiture Date _____ Type of Medication ______ Quantity _____ Time to Administer _____ Physician Name & Number ______ Pharmacy Number _____ Is there an other information that we should be aware of regarding your child's medicine or medical concerns? Staff must fill out the information below each time a child is given their medication. Date ______ Time _____ Initial _____ Date _____ Time ____ Initial ____ Date ______ Time _____ Initial _____ Date _____ Time ____ Initial _____ Date ______ Time _____ Initial _____ Date ______ Time _____ Initial _____ Date ______ Time _____ Initial _____ Date______ Time_____ Initial _____ Date ______ Time _____ Initial _____ Date ______ Time _____ Initial _____ Date ______ Time _____ Initial _____ **Authorization to** TWO RIVERS YMCA 2040 53rd Street Administer Medication Moline, IL 61265 I give permission to Two Rivers YMCA staff to administer medication to my child. Child's Name Parent's Signiture _____ Date _____ Type of Medication ______ Quantity _____ Time to Administer _____ Physician Name & Number ______ Pharmacy Number _____ Is there an other information that we should be aware of regarding your child's medicine or medical concerns?

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