CONSENT TO ADMINISTER MEDICATION

Part One: PRESCRIBED OR OVER THE COUNTER MEDICATION BEING SENT TO CAMP WITH YOUR CHILD (Medication must come in original bottles or packaging)

I authorize the administration of ______________________________________
(write name(s) of medication(s) here)

to ___________________________________ by the Camp Nagiwa Director or
(write child's name here)

staff designated by the Camp Director.

Start Date:___________________End Date:_________________________

Reason Prescribed: _______________________ Dosage: _____________

To be given at the following times: ____________________________

Refrigerate? Yes ________ No _________

Side Effects to Look For:______________________________________

Stop Medication if the following reaction(s) occur:

____

Prescribing Physician's Name: __________________________________

Physician's Office Phone Number:__________________________________

Part Two: MEDICATION ADMINISTRATION AT CAMP FOR COMMON CONCERNS

I authorize the administration of the following medications for the following occurrences (*check those that you give permission for*):

- ☐ Pain (e.g. Tylenol) _________________________________
- ☐ Inflammation (e.g. Advil) ____________________________
- ☐ Antihistamine (e.g. Benadryl) _________________________
- ☐ Anti Nauseant (e.g.Gravol) ___________________________

All of these medications will only be administered using the dosage recommended for your child's age and weight. The camp reserves the right to substitute generic brands of medication.

PART THREE: I, the parent or legal guardian or the above named child, shall notify the YMCA-YWCA in writing if there is a cancellation or change to any medications listed above. I further give permission for designated YMCA-YWCA personnel or its agents to administer the above medication(s) to my child, or for my child to self-administer, if applicable. This form shall also permit designated YMCA-YWCA personnel or its agents to share and request relevant health information regarding the administration of this medication. I acknowledge that medications are NOT given by licensed medical personnel, and that a physician-patient relationship in not formed as a result of this Consent. I agree that the YMCA-YWCA and its agents who are acting within the scope of their duties shall be held harmless in any and all claims or actions arising from the administration of the above noted medication.

Medication Allergies or Sensitivities:

____

____

DATE: _________________ PARENT SIGNATURE:______________________

(RECORD OF ADMINISTRATION TO BE COMPLETED ON BACK OF SHEET BY DESIGNATED STAFF)