MEDICATION AUTHORIZATION FORM
Greater Joliet Area YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child's Name: _____ Age: _____

Physician's Name: _____

I give permission for the Greater Joliet Area YMCA program staff to administer the following prescribed medication for a period of_____.

Medication	Dosage	Time to be given

Possible Side Effects _____

For regularly prescribed medication, I understand that:

- YMCA staff may dispense ONLY MEDICATION WITH A PRESCRIPTION LABEL (you can ask any pharmacist to put a pharmacy label on over the counter medication). Any medication dispensed to a child at the program site must be in its original container with the child's name on it.
- Please note that the YMCA staff are NOT allowed to give the first dosage of any medication. YMCA staff are not permitted to give medication to control or contain fever. If your child refuses medication, we will contact you for further instructions.
- YMCA staff may only dispense medication on this form.

Parent/Guardian Signature _____ Date _____

Site Director's Signature _____ Date _____

TO BE COMPLETED BY YMCA STAFF

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Date					
Time					
Medication					
Dose					
Initials					
Date					
Time					
Medication					
Dose					
Initials					
Date					
Time					
Medication					
Dose					
Initials					

GREATER JOLIET AREA YMCA
1801 W. Jefferson Street | Shorewood, Illinois 60404
(815) SAY-YMCA | www.jolietymca.org

UNITED WAY

MEDICATION AUTHORIZATION FORM: OVERNIGHT

Emergency Medical Treatment Authorization

I, the undersigned parent/guardian of the above-named minor, authorize designated YMCA staff to seek and obtain emergency medical treatment for my child if I cannot be reached in a timely manner.

This authorization includes transportation by emergency medical services (EMS) or Coaches, and treatment by licensed medical professionals as deemed necessary.

I understand that every reasonable effort will be made to contact me prior to any treatment.

Parent/Guardian Initials: _____

Authorization for First Dose of Prescription Medication (Emergency Only)

I authorize trained and designated YMCA staff to administer a first dose of my child's prescribed medication in an emergency situation only when:

- The medication is prescribed to my child and provided in its original labeled container
- Administration is necessary to prevent significant harm or worsening of the condition
- A delay in administration would pose a risk to my child's health
- Staff follow YMCA medication administration and documentation protocols

I understand that:

- This authorization is limited to emergency situations during overnight programs
- YMCA staff are not acting as medical professionals
- All administrations will be documented and communicated to me as soon as possible

Parent/Guardian Initials: _____

Acknowledgment & Consent

I acknowledge that I have provided accurate medical and medication information for my child. I understand the policies governing medication administration and emergency care within YMCA programs and consent to the above authorizations.

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

Insurance Information

Primary Insurance Provider: _____

Policy Holder Name: _____

Relationship to Participant: _____

Insurance Company Phone: _____

Policy Number: _____

Group Number: _____

Primary Care Physician: _____

Physician Phone: _____

Authorization to Bill Insurance

I authorize medical providers to release information necessary to process insurance claims and to bill my insurance provider listed above for services rendered.

Parent/Guardian Initials: _____