Northeastern Ontario
Shine On

YMCA of Northeastern Ontario
Child, Youth & Family Development

Authorization for Prescription Medications

Name of Child:			
Medication Name:		**Medication Type:** (Inhaler, Cream, Capsule, etc.)	
Reason for Medication:			
Date Prescribed:		**Dosage to Administer:**	
Time(s) to Administer:			
Expiry Date:		**Prescription (RX) Number:**	
Medication Start Date:		**Medication End Date:**	

The YMCA of Northeastern Ontario will not administer over-the-counter medication for the sole purpose of reducing a child's fever, cough or malaise symptoms unless noted by a physician detailing that the condition required medication. The doctor's note should include:

- Why the medication is required;
- Instructions for administering;
- Time(s) to administer;
- The exact dosage;

All medication must be in its original container with the pharmacy label affixed.

If your child is school-aged and is going to carry their own Epi-Pen or Puffer, we also require a physician's note. If a child is self-administering this medication, they must notify a staff member before doing so.

Medication must be hand-given to a YMCA of Northeastern Ontario Staff member and will then be stored appropriately and kept out of the reach of the children. Medication must never be left in the child's cubby or backpack.

The below section must be completed <u>by the parent and/or guardian.</u>

Please list any possible side effects (if applicable) *or attach the pharmacy list:

Medication must be stored in (please check): ☐ Fridge Box ☐ Counter Box ☐ on/with Educator

All parents and/or guardians must follow the instructions of the YMCA of Northeastern Ontario's Medication Procedure, which was given in your Registration Package at the time of registration.

I hereby authorize the YMCA of Northeastern Ontario Staff to administer the above medication to my child as per the above directions.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____

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Dispensing Record

Child's Name: _____

As a best practice, to ensure that the correct dosage is given, **it is highly recommended (where possible) to have another educator colleague or Supervisor verify your medication measurement and cross reference the amount with the actual prescription bottle or doctor's note.** The second staff (Staff 2) will initial next to the staff lead (Staff 1) who is administering the medication.

Date	Time	Dosage Given & Additional Notes	Staff 1 Initials	Staff 2 Initials

When the above dispensing record form is full, please begin a new one and attach the forms (if the medication is being continued). Please sign and date the below before switching to a new form or once the medication is completed.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____