FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Parental Release for the Administration of Prescribed Medications and Over-The-Counter Medications (including diaper cream, sunscreen and lotions)

I, _____, the parent/legal guardian of _____ (hereinafter "my child"), a minor enrolled in a Westfield Area Y program, do hereby authorize the Westfield Area Y accordance with the prescription/direction of

Dr. _____ In consideration of The Westfield Area Y programs agreeing to administer medication to my child, I hereby covenant and agree, on behalf of myself, and on behalf of my child, or heirs and legal representatives, that I will accept and assume any and all legal responsibility and risk associated with the administration of medication to my child; that I will not sue The Westfield Area Y on account of personal injuries, illness or death that may be sustained by my child as a result of the administration of medication to my child; and that I release and forever discharge The Westfield Area Y from any and all damages, and causes of action, either at law or in equity, which my child and I may have or which may accrue to us, our heirs, administrators, executors, personal representatives, successors or assigns as a result of the administration of medication to my child.

My child and I intend this to be a complete Release and Discharge of The Westfield Area Y as well as all representatives and employees of The Westfield Area Y having anything to do with the administration of medication to my child. I have read this statement of intent and fully realize and understand that I am signing the Release and Discharge on behalf of myself, my child, and our heirs, administrators, executors, personal representatives, successors, or assigns.

_____ _____

Signature Date

_____ _____

Print Name Date

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Medical Permission Form
Individual Medication Record

Today's Date_____ Westfield Y Program_____

Child's Name_____
Age_____ DOB_____

Complete Name of Medication_____
_____

Prescription _____ Non-Prescription_____

Refrigeration Necessary? YES NO (circle one)

Reason for Medication?
_____
_____

Amount to be administered? _____

Time(s) to be administered? _____ _____
_____

Possible Adverse Reactions?
_____
__

What to do if reaction to medication occurs:
_____
_____

If allergy, what is child allergic to_____

Has your child previously had an allergic reaction?_____

If yes, please describe_____
_____

****If this medication is for an Epi Pen, Asthma Inhaler or Nebulizer, please complete Action Care Plan. Available from director or on line.** MUST BE SUBMITTED PRIOR TO START DATE*****

Parent/Guardian Signature _____
Date:_____

Doctor's Name_____Dr. Phone Number
_____

Doctor's Signature _____
Date:_____

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Medication Log

Date	Time	Adverse Reaction Observed	Staff Members Signature

All medications MUST be in their original containers.

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WHAT TO DO IF YOUR CHILD NEEDS MEDICATION DURING PROGRAM TIME

If your child will need medication during program time, you must have your DR. fill out our "Authorization to Distribute Medicine" form. (Be proactive by bringing these forms with you if you are going to the Dr. for a suspected illness).

- Medication will only be distributed if proper forms are filled out and signed by a physician. (this includes over-the-counter medications with the exception of sunscreen, lotion and diaper cream)
- Over the counter sunscreen, lotion and diaper cream will only be administered if form is filled out and signed by parent.
- All medications are to be given to the director, coordinator, or supervisor.
- Children are not allowed to self administer any medication, staff will administer all medication.
- Children over the age of 4 may assist with putting on sunscreen and lotions
- Spray on sunscreen is not permitted
- All medication must be in its original container
- Medication must not be expired, and date on Epi Pen must match the box that the Epi Pen is in.
- Must provide 2 Epi Pens
- All forms and medication must be hand delivered to director of program prior to start date.
- **If your child is in need of an Epi Pen, Nebulizer or inhaler, you must complete an Action Plan. (form to be requested of the program director at Y or of your physician).**