

Pickens County YMCA
MEDICATION INFORMATION FORM

Child's Name: _____ Afterschool Site: _____

Name of Parent/Guardian: _____

Phone: Home _____ Work _____ Cell _____

Doctor's Name: _____ Office Phone: _____

Medication and Strength: _____

Dosage: _____ Storage Instructions: _____

Prescription Directions: _____

Quantity Sent to Afterschool: _____

When was the medication started: _____ Temporary: _____ Permanent _____

Reason for medication: _____

Side Effects: (reactions to food, dehydration, decreased balance, drowsiness, etc)

List other important information about this medication:

Expected action if medication is not taken as directed:

Comments:

Waiver: This information is confidential and is provided to the Pickens County YMCA for the express purpose of helping to ensure a healthy, safe experience for my child. This form may be shared with medical personnel should the necessity arise. Upon request, it will be returned to me at the end of the program.

Parent/Guardian Signature

Date

