Medication Authorization Form 2025

Camper and Parent/Guardian Information

Camper's Name:	
Date of Birth:	Program Attending:
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Emergency Telephone:	

Licensed Prescriber Information

Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:

Medication Information

Name of Medication:	
Dose given:	Purpose of Medication:
Possible Side Effects/Adverse Reactions:	
If for allergy, describe reaction symptoms:	

Authorization Information

I hereby authorize the properly trained camp staff at the North Suburban YMCA Summer Camp

to administer, to my child, _____ the medication(s) listed above.

If above listed medication includes epinephrine injection system:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

If above listed medication includes insulin for diabetic management:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

PARENT AUTHORIZATION

Each day of the program, I will send the required medication in its original, child-proof container with the pharmacy label and dosage attached. This medication will be given directly to the program supervisor. This medication is to be administered by program staff. I authorize the NSYMCA Camp staff to administer medication to my child. I hereby indemnify and release the NSYMCA, their officers, agents, servants, and employees from any and all claims from injuries, including death, physical injury or illness, damages or loss, which I and/or my child may have following the administration of the medication ordered by the above-listed physician. Only if specifically directed by parent and agreed to by the NSYMCA, a NSYMCA staff member may administer the medication and said staff member will not be a nurse or doctor.

Signature of Parent/Guardian:	Date:

North Suburban YMCA
Allergy Action Plan 2025

Camper Information

Camper Name: _____ Program Attending: _____ Date of Birth: _____

List All Allergies: _____

List Know Reactions/Symptoms when exposed to Allergen: _____

_____ Asthma: □ Yes □ No

TREATMENT

Symptoms:	**Give Checked Medication**:** **To be determined by authorizing physician
• If food allergen has been ingested, but no symptoms:	☐ Epinephrine ☐ Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue mouth	☐ Epinephrine ☐ Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• Throat+ Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• Lung+ Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• Heart+ Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Other+	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

+Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly ☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3mg ☐ Twinject 0.15mg ☐ Other:_____

Antihistamine: Give_____

Medication/dose/route

Other: Give_____

Medication/dose/route

Camper/Parent Consent to Carry and Self-Administer Medication

I give my permission for my child to carry and self-administer the above medication as directed by the HCP, which I have also signed. I agree that my child has been trained and is competent to carry and self-administer this medication. I release the NSYMA and its personnel from civil liability if my child suffers an adverse reaction as a result of self-administering the Epinephrine Auto-Injector and/or the Inhaler. I understand this permission to carry and self-administer medication may be revoked by the NSYMCA if my child does not follow Universal Precautions, if my child is observed misusing the medication or medication supplies, or if having the child carry/administer this medication on campus creates an unsafe situation for campers, staff or volunteers to the NSYMCA campus.

Parent/Guardian Signature:_____Date:_____

Parent/Guardian Consent

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with the states laws and regulations. Specialized physical health care services may be performed by unlicensed designated NSYMCA personnel under the training provided by the American Red Cross CPR/First Aid/AED Instructors.

I authorize the staff of the NSYMCA to administer medication according to the Medication Authorization Form. Do not hesitate to administer medication or call 911 even if parents or doctor cannot be reached.

Physician Name & Signature: _____ Date: _____

Parent Signature: _____ Date: _____