FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**YMCA of the East Bay**
**Albany YMCA Youth Programs**
Incidental Medical Services
Parent Authorization Agreement

Date: _____

Child's Name: _____

Parent/Legal Guardian Name: _____

My child may require Incidental Medical Services during his/her time in the YMCA program. These services may include (initial by all that apply):

____Taking an oral medication
____Taking an inhaled medication
____Using an epi-pen
____Other (please describe _____)

Please choose and initial authorization of training from the options below:

____I understand that YMCA staff are trained in American Red Cross Pediatric First Aid or an EMSA approved class, and that this training describes how to handle administering oral medication, inhaled medication, and the use of an epi-pen. I authorize this training as acceptable in handling an Incidental Medical Service that may occur with my child.

____I prefer to train the staff myself in handling an Incidental Medical Service that may occur with my child and certify I've trained the staff listed below to administer the following medication(s): _____

| Staff Name: | Date Trained: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I authorize the trained staff at the Albany YMCA Y-Achievers site to administer Incidental Medical Services to my child.

_____ _____
Parent Signature Date