

**NAVY CHILD AND YOUTH PROGRAMS  
MEDICATION ADMINISTRATION FORM**

REQUIRING DIRECTIVE OPNAVINST 1700.9

**NAVY CYP MEDICATION ADMINISTRATION FORM**

It is preferable that medication not be administered within the CYP Programs. When possible, parents and physicians should adjust medication schedules so that the program staff are not responsible for administration. We recognize that this is not always possible and we will agree to administer any medication as follows:

- Written orders by a physician must be on file in order to administer any medication.
- Parent/legal guardian must sign the liability release.
- Child shall be monitored on the medication for 24 hours each time medication is prescribed before the program staff administers medication.
- Children who need medications administered for extended time periods, or that have special health concerns will be required to complete Special Needs paperwork and be reviewed by the special needs review board.

**ALL INFORMATION IN THIS SECTION MUST BE COMPLETED LEGIBLY BY A PHYSICIAN**

\_\_\_\_\_  
**Name of Child**

\_\_\_\_\_  
**Name of Medication to be Administered by CYP Staff**

\_\_\_\_\_  
**Time of Day and/or Frequency Medication is to be Administered**

\_\_\_\_\_  
**Duration of Medication (Dates)**

\_\_\_\_\_  
**Any Known Allergies**

**Can this medication schedule be adjusted so the medication is administered outside the CYP hours only?**  YES  NO

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date of Order**

**PARENTAL CONSENT/WAIVER/RELEASE AND INDEMNIFICATION**

I hereby give consent for the CYP staff to administer medication to my child as directed above by the physician. I agree to indemnify and hold harmless Navy Child and Youth Programs, MWR, a non-appropriated fund instrumentality of the United States Navy, and any other instrumentality of the United States, and their officers, agents, and employees from any losses, expense, damage, claim, suit, or judgment arising out of or resulting from administration of medication to my child. As the parent/legal guardian, I agree to assume all risk associated with administration of medication including inadequacy or failure of staff and I also assure the said medication is safe for my child.

\_\_\_\_\_  
(Print) Parent Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date