Medication Form

Child's Full Name:_____

Date of Birth:_____

ALLERGIES and MEDICATION If your child is allergic to any known allergen, for example, food items such as peanuts and seafood; plant items such as poison ivy; insects such as bees and wasps; animal fur, PLEASE LIST ALL ALLERGENS below and the type of reaction and medication needed. If your child needs an EpiPen for any allergen, an inhaler, diabetes device or any other prescribed medication, please list below expiration date of prescription and doctor's signature for administering the medication.

❑ CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN. ❑ CHECK HERE IF MEDICATIONS ARE ROUTINELY TAKEN AND LIST ANY MEDICATIONS ON THE CHART BELOW. If additional space is needed, please complete on separate form and attach.

Please note that all prescription medications must be in the original container from the pharmacy and labeled with the prescribing doctor's name and with the expiration date of the prescription. Expired prescriptions cannot be administered under any circumstance.

PARENT AND PHYSICIAN SIGNATURES - If no prescription medications are taken, then only the parent/guardian must sign. If prescription medications are taken, then both the parent/guardian and the physician signatures are REQUIRED.

Administration of the above medications is approved for youth by:

Parent/ guardian signature: _____ Date: _____

Physician Name: _____ Physician Address: _____

Physician Phone Number: _____ Physician Emergency Phone Number: _____

Physician Signature:_____ Date: _____