

MEDICATION FORM

All medication must be in original containers.

Delegate's Name _____ County _____

Delegate's Age _____ Delegate's Weight _____ Room Assignment _____

INSTRUCTIONS: The following **must be completed for each prescription** that is to be taken by your child during this 4-H program. Please list medication in the order in which they are to be taken. **This includes inhalers.**

	Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____
BREAKFAST	Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____ Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____
LUNCH	Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____ Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____
DINNER	Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____ Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____
BEDTIME	Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____ Medication Name: _____ Dosage: _____ # of Pills sent with delegate _____ Special Instructions: _____

PARENT DECLARATION

I, _____ (Parent/Guardian Name), as the parent or legal guardian of _____ (Participant's Name), understand that the Emergency Medical Technician or designee of the program will see that my child takes his/her medication as it is prescribed or directed above. In the event that my directions differ from those on the original container, I understand that I must obtain a note from the prescribing physician confirming the directions that should be followed in administering medications to my child. Furthermore, I understand that if there are any questions or concerns, I may be contacted.

Signature _____

Date: _____