

Medication Information Form

Last Name

First Name

Age

Use this form to itemize each medication accompanying the youth to the event.
Every prescription medication must be in its original container with the correct person's name of the label.
 Over-the-counter and non-prescription medications must be in their original container(s).

/-----For Director Use Only -----/

Director <input checked="" type="checkbox"/>	Drug Name / Strength	Dosage	Frequency	Friday	Saturday	Sunday
				<input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon
				<input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon
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				<input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon

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