



Prescription Medication Form

MUST BE COMPLETED FOR EACH EVENT

All students must complete and return this form before they are able to attend EACH event.
We cannot dispense Acetaminophen/ Ibuprofen without this form.
All students should turn in clearly marked prescription medications upon arrival.

Date: _____

Name of Student: _____

Name of Parent or Guardian: _____

Home Phone #: _(____)_____ - _____ Cell #: _(____)_____ - _____

Medical or other allergies: _____

Medication to be taken during the event:

1) Name: _____ Dosage: _____

Time to be taken: _____

2) Name: _____ Dosage: _____

Time to be taken: _____

3) Name: _____ Dosage: _____

Time to be taken: _____

4) Name: _____ Dosage: _____

Time to be taken: _____

My child may be given Acetaminophen: Circle One: Yes or No

My child may be given Ibuprofen for minor pain/ headache: Circle One: Yes or No

I hereby give permission for this medical information to be shared on a need to know basis.

Parent Signature

Date