Medicine Dispense Form 2024

Participate Name: _____

Participate Age: _____ Participate Gender: _____ Male _____ Female

Emergency Contact Information:

Parent/ Guardian Name: _____

Parent/ Guardian Cell Phone Number: _____

Parent/ Guardian Work Phone Number: _____

Secondary Contact Name: _____

Secondary Contact Cell Phone Number: _____

Secondary Contact Work Phone Number: _____

Medical Info:

Current medical needs being treated for: _____

Please note any medical history to be aware of: _____

_____

Medication(s) that this participant currently takes/ needs: _____

_____

Instructions on administering medication(s) or does this student administer to self?

_____

Any Allergies: _____

Special Diet needs to be aware of: _____

Do we have permission to give your student (please check any/ all that are approved):

_____ Tylenol _____ Advil _____ Motrin _____ OTC Allergy Medicine

Primary Physician: _____ Phone: _(_____)_____

I authorize the Youth Staff of First Baptist Friendswood or their representative to give my child the medication(s) indicated above.

Signature of Parent/ Guardian: _____

Printed Name of Parent/ Guardian: _____

Date: _____