Youth Ministry Medical Information Form

Complete this form only if medication is to be administered during youth ministry programs.

RAY & JOAN KROC CORPS COMMUNITY CENTER QUINCY, IL

YOUTH INFORMATION

NAME (FIRST, LAST)

BIRTHDATE | GENDER | CURRENT AGE

PROGRAM(S) | CURRENT GRADE

PARENT/GUARDIAN(S) INFORMATION

NAME | WORK PHONE

PRIMARY PHONE | SECONDARY PHONE

NAME | WORK PHONE

PRIMARY PHONE | SECONDARY PHONE

MEDICATION GUIDELINES

Medications must be dropped off and picked up each day by a guardian or authorized adult. Any medications left overnight for the registered session will be documented in the centrally stored medication log. All medications are stored in locked containers in a locked cabinet. Medications will be administered by designated health supervisors. ***Only medications in their original package with prescription label are accepted.***

PHYSICIAN INFORMATION

PHYSICIAN'S NAME _____

PHONE _____

HOSPTIAL _____

SIGNATURE _____

DATE _____

MEDICATION INFORMATION

Please fill out one section per medication.

MEDICATION NAME | STRENGTH | DOSAGE

ADMINISTRATION INSTRUCTIONS *(IE: at mealtime)* | STORAGE INSTRUCTIONS

QUANTITY SENT TO CAMP | QUANTITY PRESCRIBED

DATE PRESCRIBED | EXPIRATION DATE | PERMANENT | TEMPORARY *(List dates)*

REASON FOR MEDICATION

POSSIBLE SIDE EFFECTS *(IE: reaction to food, dehydration, stress, restrictions on activity)*

WHICH, IF ANY, OF THE ABOVE SIDE EFFECTS HAS YOUR CHILD EXPERIENCED?

TO WHAT EXTENT?

OTHER IMPORTANT INFORMATION REGARDING MEDICATION

EXPECTED CONSEQUENCES IF MEDICATION IS NOT TAKEN AS DIRECTED

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PERMISSION TO CARRY AUTHORIZATION

Parent/Guardian(s) may allow their child to carry and administer medications needed for life-threatening conditions such as epi-pens for anaphylactic reactions and asthma inhalers. Prior approval is required for other medications to be carried.

By signing below, the parent/guardian(s) acknowledges that their child has been informed of all pertinent information regarding this medication and has authorized for youth to self-administer as directed.

Parent/Legal Guardian (printed) _____

Signature_____ Date _____

By signing below, the child acknowledges that she/he fully understands the purpose for and administration of the above mentioned medication.

Youth's Name (printed) _____

Youth's Signature_____ Date _____