

Please fill this form out for each medication that you want dispensed for your child. A new form will need to be completed every two weeks.

Child's Last Name _____ Child's First Name _____

Parent/Guardian Last Name _____ Parent/Guardian First Name _____

All medication brought to Club J must be in its original bottle/container.

Name of medication _____ Dosage _____

Prescription # _____ Amount of medication to be dispensed _____

Time medication is to be given _____ Dates to be given _____

Parent/Guardian Signature _____ Date _____

FOR CLUB J USE ONLY

	DATE	TIME ADMINISTERED	AMOUNT	REACTIONS	ADMINISTERED BY
1				<input type="checkbox"/> Yes <input type="checkbox"/> No	
2				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3				<input type="checkbox"/> Yes <input type="checkbox"/> No	
4				<input type="checkbox"/> Yes <input type="checkbox"/> No	
5				<input type="checkbox"/> Yes <input type="checkbox"/> No	
6				<input type="checkbox"/> Yes <input type="checkbox"/> No	
7				<input type="checkbox"/> Yes <input type="checkbox"/> No	
8				<input type="checkbox"/> Yes <input type="checkbox"/> No	
9				<input type="checkbox"/> Yes <input type="checkbox"/> No	
10				<input type="checkbox"/> Yes <input type="checkbox"/> No	

If noticeable adverse reaction to medication, what action was taken? Describe:
