

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:

\_\_\_\_\_

My Child will NOT need medication dispensed to them at CLUB J: \_\_\_\_\_

Parent Signature

Date