



Youth Medical Information

2017

Participant's Name: _____

Please list any relevant information staff needs to know. (asthma, ADHD, diabetes, seizures, etc:)

Is the participant allergic to any medications or foods? _____ Yes _____ No (if yes, please list)

If your child requires daily medication please provide the **Medication Information** below.

Name of Medication: _____

Physician's Name: _____ Phone: (____) _____

Reason for Medication: _____

Dosage Prescribed: _____

When it needs to be administered: _____

How it needs to be administered: _____

Refrigeration Required: _____ Yes _____ No

LLELA/City of Lewisville staff are not able to administer medication, but can store it until your child needs it. If you send medication with your child, you are giving permission for your child to administer it him/herself.

Medical Waiver

All medication must be in proper prescription bottle(s) with the instructions for the administration of the medicine on the label. If there are any changes in the dosage, time, frequency or administration of the medication, it is the participants'/parents'/guardians' responsibility to inform the staff in writing. The undersigned acknowledges that instructions on the pharmaceutical container are accurate.

IF YOU DO NOT ALLOW PERMISSION FOR THE ABOVE STATED PROCEDURES, MEDICATIONS WILL NOT BE DISPENSED WHILE PARTICIPANT IS ATTENDING LEWISVILLE PARKS AND RECREATION PROGRAMS

Signature: _____ Date: _____