Youth Medical Information 2019

Participant's Name: _____ (ONE CHILD PER FORM)

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)

_____

1st Emergency Contact name/phone number: _____

2nd Emergency Contact name/phone number: _____

_____

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

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 DIPENSED WHILE PARTICIPANT IS ATTENDING LEWISVILLE PARKS AND RECREATION PROGRAMS

Signature: _____ Date: _____