

Youth Medication Form

EACH MEDICATION MUST BE ON ITS OWN FORM.

**Photocopy as necessary, or download additional forms at www.CornerstoneChapel.net.
Form must be complete and medication must be in its original container to be accepted.**

Authorizing Parent Cell Phone _____
Authorizing Parent Day Phone _____
Prescriber's Name _____ Phone _____

Minor's First & Last Name _____

Minor's Birthdate ___/___/_____

Minor's known allergies _____

Name of Medication _____

Amount/Dosage to be given _____

Route of Medication _____

Frequency to be administered _____

Identify any symptoms that necessitate administration of medication.

Possible side effects (parent must supply package insert or pharmacy printout for complete list of possible side effects). _____

What action should be taken if side effects are noted?

Contact Parent Contact Prescriber

Other (describe) _____

Are there any special instructions or concerns related to possible interactions with other medications the minor is receiving or concerns regarding the use of the medication as it relates to the minor's age, allergies or any pre-existing conditions? _____

Describe situations when medication should not be administered.

I, the parent/legal guardian, authorize Cornerstone Chapel to administer the medication as specified to (Minor's name) _____

PRINT Parent Name _____

Parent Signature _____

Date _____