



Request for Administration of Medication

Please attach to Health Form and update as necessary

Name of Member _____ Date of Birth _____

Address _____

Diagnosis _____

Reason Medication must be given at AHG event _____

Name of Medication: _____

Dose: _____ Time to be given: _____

Dates to be given: _____

Instructions: _____

Contraindications: _____

Side Effects: _____

Treatment of Side Effects/Action to be taken: _____

Is any restriction on activity necessary? Yes _____ No _____

If yes, describe: _____

Is the AHG member on any other medications? Yes _____ No _____

If yes, name medication: _____

Print Doctor's Name: _____

Address: _____ Phone: _____

This is an emergency medication (i.e. inhaler, epi-pen) and must be kept on child's person

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I authorize selected AHG personnel to administer the above prescription medication as prescribed by my health care provider. If the medication is an over-the-counter medication I authorize its use according to the provided instructions. I authorize the Troop Leader to contact my child's health care provider as needed regarding this medication and/or my child's response.

Parent Signature _____ Date: _____

Telephone: _____ Emergency number: _____