



Medication Form

Youth Name: _____

Parent / Guardian Name: _____

Parent / Guardian Phone: (Daytime) _____ (Evening) _____

Instructions:

Please complete this form for all medication(s) your child will be taking as needed while on a youth ministry trip including over-the-counter medications for headaches or cold, inhalers, etc.

Note:

This form must accompany your child only if he/she is taking any medication. Please read the following information related to the "Medication Policy" Oak Grove Youth Ministry. Your signature below indicates that all information provided on this form is correct and that you understand our medication policy

	Medication Name (include any special instructions)	As Needed	Breakfast	Lunch	Dinner	Bedtime
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medication Policy

- ✓ All medications (over the counter and/or prescription) must be submitted at drop off time.
- ✓ All medication must be in the ORIGINAL CONTAINER with the youth name printed on the bottle.

THERE WILL BE NO EXCEPTIONS TO THIS POLICY.

My signature below indicates I have read and understand this policy. I hereby authorize the staff or adult volunteer leader of Oak Grove UMC youth ministry to dispense medication to my child as stated above.

Parent / Guardian Signature

Date