COPPELL YOUTH PROGRAMS
MEDICINE FORM

Child's Name:	Date:

Parent's Names:	Camp: Camp Do-It-All
Daytime Emergency Phone Number:	

Dates medicine is to be given:

- θ ◯ For entire program.
- θ ◯ For the week of -_____
- θ ◯ For the dates of - _____
- θ ◯ When my child displays these behaviors:_____
  _____
  _____

MEDICINE INFORMATION:

Name of Medication:_____

Physician's Name & Phone #:_____

Reason for Medication: _____

Dosage Prescribed: _____

Time to be administered: _____

Special Instructions: _____

Refrigeration Required? ☐ Yes ☐ No

Potential Side Effects/Warnings Associated with Medication:

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date