Request for Administration of Medication

Please attach to the AHG Health and Medical History Form and update as necessary.

AMERICAN HERITAGE GIRLS™
FAITH | SERVICE | FUN

Name of Member: _____ Date of Birth: _____

Address: _____

Diagnosis: _____

Reason Medication must be given at an 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 of medication: _____

Print Doctor's Name: _____

Address: _____ Phone: _____

YES/NO This is an emergency medication (i.e. inhaler, epi-pen) and must be kept on child's person.

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: _____