

MEDICATION FORM

St. Michael's Youth Mission Trip 2010

Missionary's Name _____

Name of Parent or Guardian _____ Phone () _____

Doctor's Name _____ Phone () _____

Medication/Strength (Please list all medications to be taken): _____

Reason for Medications: _____

Expected Schedule (e.g., 3 times a day, as needed, etc): _____

When were medications started? _____

Possible Side Effects (reactions to foods, dehydration, stress, iodine, other meds. Decreased balance, motor activity, concentration, drowsiness, lethargy, etc.): _____

List other important information about these medications since access to medical information or facilities could be delayed due to geographical area.

Special Storage Instructions: _____

Expected result if medicine is not taken as _____

Total quantity needed for the week: _____

Do we have your permission to provide over the counter medications such as (but not limited to) Tylenol, Pepto Bismo, Immodium A/D, Alka Seltzer, etc. to your son? _____ Yes, _____ No, Parent Initials _____

WAIVER: This information is confidential and is provided to Mike Marshall, Coordinator of Youth Ministry

For the express purpose of helping to ensure a healthy, safe mission experience for my child, this form may be shared with medical personnel should the necessity arise. It will be returned to me at the end of the trip.

Signature of Parent/Guardian _____ Date _____