

PRESCRIPTION MEDICATION FORM

St. Michael's Youth Mission Trip 2009

****If your youth needs, or may need PRESCRIPTION medication during this trip, please complete below. Parent must specifically authorize all PRESCRIPTION medication below. Parent must provide this medication. Each medication must be in the original container clearly labeled with name, name of medication and instructions. HAND THIS FORM WITH MEDICINE INSIDE A ZIP-LOCK BAG ON DAY OF CHECK-IN.**

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: _____

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 _____
