Florida 4-H Medication Form

Youth Name: _____ 4-H County: _____

Directions for Parents and Guardians: Please complete this form for any medication your child will be taking while attending any 4-H activity, including non-prescription drugs, lotions, inhalers or any other items. This form **must** accompany your child's medication for the activity. Any medication not meeting the following requirements will not be allowed at a Florida 4-H activity.

All prescription medications **MUST**:

- Be in the original container with a prescription label
- Be properly labeled with the youth's name, dosage, & frequency
- Have directions that match what is prescribed
- Have the doctor's name and prescription number
- Not be expired
- Sample medications must have a written prescription from doctor

Special consideration for inhalers and/or Epinephrine ("EpiPen"):

- The inhalers and/or EpiPens should be in their prescription box with their prescription label.
- If you've thrown out the box, your pharmacy can print you a label to bring, but it must match the medication and still be in date.
- We **cannot** accept expired inhalers or EpiPens.

All over the counter medications (includes ear drops/swim ear, allergy meds, pain relievers, vitamins etc.) MUST:

- Be in the original container
- Marked with youth's name
- Not be expired

I request that a person designated by Florida 4-H give my child, _____ the following medication:

1) Name of medication: _____
Amount to be given: _____
Time of day to be given: _____
Directions, if to be given "as needed": _____
Dates medication is to be given: From ____/____/____ To ____/____/____
Prescribing doctor's name: _____
Illness or condition prescribed for: _____
If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?
Yes ____ or **No**____

I agree to furnish Florida 4-H with the medication(s) listed on this form per the guidelines above. I further understand that Florida 4-H's designated person will administer the medicine to my child in good faith, at request. I certify that I have signed the Florida 4-H Medication Consent provision in addition to this form.

_____ _____
Parent/Guardian Signature Date

If you are sending more than one medication for your child, please complete the second page of this form. ⇨

Youth Name: _____ 4-H County: _____

Additional Medications

2) Name of medication: _____
Amount to be given: _____
Time of day to be given: _____
Directions, if to be given "as needed": _____
Dates medication is to be given: From ____/____/____ To ____/____/____
Prescribing doctor's name: _____
Illness or condition prescribed for: _____
If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?
Yes ____ or **No____**

3) Name of medication: _____
Amount to be given: _____
Time of day to be given: _____
Directions, if to be given "as needed": _____
Dates medication is to be given: From ____/____/____ To ____/____/____
Prescribing doctor's name: _____
Illness or condition prescribed for: _____
If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?
Yes ____ or **No____**

4) Name of medication: _____
Amount to be given: _____
Time of day to be given: _____
Directions, if to be given "as needed": _____
Dates medication is to be given: From ____/____/____ To ____/____/____
Prescribing doctor's name: _____
Illness or condition prescribed for: _____
If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?
Yes ____ or **No____**