Assumption Youth Ministry

LUKE 18

MEDICATIONS FORM

Date _____ 8th Grader Name _____

Prescription medications that need to be administered must be sent in the original pharmacy container labeled with the exact dosage and name of the minor and the prescribing doctor. List all prescription medications here:

Name of medication Dosage Times to be given # of doses sent Given for treatment of

_____

_____

_____

_____

This information is sensitive and therefore not required, but is critical knowledge in an emergency situation and for your protection and safety.

Over-the-Counter medications (OTC) (non-prescription) should be sent in unopened individual dose packets, or in unopened original packaging if possible. If sending open packaging, please send only the number of doses needed for the time period necessary plus one extra dose if timing is critical. Over-the-counter medications must have minor's name on them. List all OTC medications here:

Name of medication Dosage Times to be given # of doses sent Given for treatment of

_____

_____

_____

_____

This information is sensitive and therefore not required, but is critical knowledge in an emergency situation and for your protection and safety.

ALL MEDICATIONS MUST HAVE MINOR'S NAME ON THEM!

_____ _____ _____

Parent/Guardian signature (self if over 18) *Relationship to minor* *Date*

This medications form must be filled out for each Youth Ministry activity requiring medications to be given by Youth Ministry Coordinator or an adult representative.

Assumption Youth Ministry

LUKE 18

MEDICAL AID AUTHORIZATION FORM

I/We, the undersigned PARENTS/GUARDIANS of _____ do hereby authorize the Assumption Youth Ministry coordinator or an adult representative of Assumption Youth Ministry to obtain whatever medical aid for MY/OUR minor that might be necessary during Youth Ministry activities or transportation to or from said activities. I/WE further indemnify and hold Assumption Parish, the Youth Ministry Coordinators and/or accompanying adult(s) harmless from any and all claims for medical expenses arising from such medical aid so rendered to or for mentioned minor or adult. This form is to be updated yearly or on an as needed basis.

EMERGENCY MEDICAL INFORMATION

Birth date_____

Known allergies (all types) _____

Prescription and non-prescription medications minor/adult is taking _____

Existing medical conditions_____

Previous surgeries and other pertinent medical information_____

Insurance Company_____ Carrier's Name _____

ID #_____ Group/Policy # _____

Doctor's Name_____ Office Phone # _____

Address _____ Exchange Phone # _____

Father/Guardian's Name_____ Home Phone _____

Address _____ Cell Phone _____

Mother/Guardian's Name_____ Home Phone _____

Address _____ Cell Phone _____

EMERGENCY CONTACT IN THE EVENT WE CANNOT BE REACHED:

Name_____ Home Phone _____

Address _____ Other Phone _____

Relationship to minor _____

Medications are listed on a separate Medications Form

_____

Parent/Guardian signature (self if over 18) *Date*