# Medicine Form

Participant Name: _____

Participant Age: _____ Participant Gender: _____ Male _____ Female

**Emergency Contact Information:**

Parent/Guardian Name: _____

Parent/Guardian Cell Phone Number: _____

Parent/Guardian Work Phone Number: _____

Secondary Contact Name: _____

Secondary Contact Cell Phone Number: _____

Secondary Contact Work Phone Number: _____

**Medical Info:**
Current medical needs being treated for: _____

Please note any medical history to be aware of: _____

---

Medication(s) that this Participant Currently Takes/Needs: _____

_____

Instructions on administering medication(s) or does student administer to self?

---

Any allergies: _____

Special Diet needs to be aware of: _____

Do we have permission to give your student (please check any/all that are approved):

_____Tylenol _____Advil _____Motrin _____ OTC Allery Medicine

Primary Physician: _____ Phone: (_____)_____

*I authorize the Youth Staff of First Baptist Friendswood or their representative to give my child the medication(s) indicated above.*

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Date: _____