

MEDICATION FORM *for* RECHARGE 2023

Small group leader's name(s): _____

Parent Name: _____

Parent phone number: _____

Please complete and bring *WITH ALL MEDICATION* on the day of drop off.

Student's name _____ **Student's grade:** _____

Please list ALL medications (prescriptions, vitamins, over-the-counter):

Medication and reason for use <i>(Example: Amoxicillin for ear infection)</i>	Dosage and frequency <i>(Example: 1 tablet, 3x/day)</i>	Check all that apply
		<input type="checkbox"/> 8:00 AM <input type="checkbox"/> 12:00 PM <input type="checkbox"/> 5:30 PM <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed
		<input type="checkbox"/> 8:00 AM <input type="checkbox"/> 12:00 PM <input type="checkbox"/> 5:30 PM <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed
		<input type="checkbox"/> 8:00 AM <input type="checkbox"/> 12:00 PM <input type="checkbox"/> 5:30 PM <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed
		<input type="checkbox"/> 8:00 AM <input type="checkbox"/> 12:00 PM <input type="checkbox"/> 5:30 PM <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed

Please attach additional sheets if necessary to include all medications.

****All prescription medications must be in the correctly labeled container with name and dosage.**

Parent/Guardian's signature _____ Date _____