

St. John Youth Group

MEDICATIONS/ALLERGY INFORMATION FORM

Please indicate below any medications your child is currently taking. If medication is to be administered by an adult during a youth event, indicate the name, dosage and time medication is to be given. Also list **any** allergies your child has to foods, medicines, etc.

Youth _____ Cell # _____

Medication presently on (name & dosage for each):

Allergies (Foods, Medications, Bee Stings, etc.): Please include possible signs of reaction as well as procedures to follow.

Any medical conditions (such as, but not limited to Asthma, ADD/ADHD, migraines, heart, lung, and diabetes history, etc.) Please include any information supervising adults need to know regarding this condition.

Date of last Tetanus shot _____

I hereby grant permission to any staff person on the trip to provide the following over-the-counter drugs to my child if requested by my child while in their care. (Check all that apply):

___ Tylenol/Acetaminophen ___ Benadryl ___ Advil/Ibuprofen ___ Neosporin

___ Pepto-Bismol ___ Imodium AD ___ Hydrocortisone Anti-Itch Cream ___

Other _____

Parent Signature _____ Date: _____