

Chapel West Eternal Flame Pathfinders Medication Release Form

This form **MUST** be filled out and signed in order for the Pathfinder adult supervisor to administer any needed medications (both prescription and non-prescription such as Ibuprofen, Tylenol, allergy medication, etc.) All prescription drugs **MUST** be carried in the container in which they were issued (with medical orders, Pathfinder's name and physician's name intact) and given to the adult leader. **Send ample supplies.** Over the counter medications you provide must also be in original containers. List below all medications your child may need to be given while at Pathfinder activities. Use addition pages as needed.

Pathfinder's name _____ Age _____ Weight _____

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Name of medication _____

Condition for which taken _____

Amount to be taken _____ Time(s) to be taken _____

Name of medication _____

Condition for which taken _____

Amount to be taken _____ Time(s) to be taken _____

Name of medication _____

Condition for which taken _____

Amount to be taken _____ Time(s) to be taken _____

NON-PRESCRIPTION MEDICATION

Drug	Schedule (as needed)	Permission to Administer	Comments
Tylenol for age/wt	Every 4 hrs for pain/fever	Yes/No	
Ibuprofen for age/wt	Every 6 hrs for pain/fever	Yes/No	
Robitussin for age/wt	Every 4 hrs for cough	Yes/No	
Benadryl for age/wt	Every 6 hrs for allergic reaction (hives, insect bites, etc)	Yes/No	

The adult supervisor has my permission to administer the above medication(s)

Parent of Guardian Signature _____ Date _____