



# Florida 4-H Medication Form

Youth Name: \_\_\_\_\_

4-H County: \_\_\_\_\_

**Directions for Parents and Guardians:** Please complete this form for any medication your child will be taking while attending any 4-H activity, including non-prescription drugs, lotions, inhalers or any other items. This form **must** accompany your child's medication for the activity. Any medication not meeting the following requirements will not be allowed at a Florida 4-H activity.

All prescription medications **MUST**:

- Be in the original container with a prescription label
- Be properly labeled with the youth's name, dosage, & frequency
- Have directions that match what is prescribed
- Have the doctor's name and prescription number
- Not be expired
- Sample medications must have a written prescription from doctor

Special consideration for inhalers and/or Epinephrine ("EpiPen"):

- The inhalers and/or EpiPens should be in their prescription box with their prescription label.
- If you've thrown out the box, your pharmacy can print you a label to bring, but it must match the medication and still be in date.
- We **cannot** accept expired inhalers or EpiPens.

All over the counter medications (includes ear drops/swim ear, allergy meds, pain relievers, vitamins etc.) **MUST**:

- Be in the original container
- Marked with youth's name
- Not be expired

I request that a person designated by Florida 4-H give my child, \_\_\_\_\_ the following medication:

**1) Name of medication:** \_\_\_\_\_

**Amount to be given:** \_\_\_\_\_

**Time of day to be given:** \_\_\_\_\_

**Directions, if to be given "as needed":** \_\_\_\_\_

**Dates medication is to be given:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescribing doctor's name:** \_\_\_\_\_

**Illness or condition prescribed for:** \_\_\_\_\_

**If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?**

Yes \_\_\_\_\_ or No \_\_\_\_\_

I agree to furnish Florida 4-H with the medication(s) listed on this form per the guidelines above. I further understand that Florida 4-H's designated person will administer the medicine to my child in good faith, at request. I certify that I have signed the Florida 4-H Medication Consent provision in addition to this form.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

**If you are sending more than one medication for your child, please complete the second page of this form.**

Youth Name: \_\_\_\_\_

4-H County: \_\_\_\_\_

**Additional Medications**

**2) Name of medication:** \_\_\_\_\_

**Amount to be given:** \_\_\_\_\_

**Time of day to be given:** \_\_\_\_\_

**Directions, if to be given "as needed":** \_\_\_\_\_

**Dates medication is to be given:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescribing doctor's name:** \_\_\_\_\_

**Illness or condition prescribed for:** \_\_\_\_\_

**If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?**

Yes \_\_\_\_ or No \_\_\_\_

**3) Name of medication:** \_\_\_\_\_

**Amount to be given:** \_\_\_\_\_

**Time of day to be given:** \_\_\_\_\_

**Directions, if to be given "as needed":** \_\_\_\_\_

**Dates medication is to be given:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescribing doctor's name:** \_\_\_\_\_

**Illness or condition prescribed for:** \_\_\_\_\_

**If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?**

Yes \_\_\_\_ or No \_\_\_\_

**4) Name of medication:** \_\_\_\_\_

**Amount to be given:** \_\_\_\_\_

**Time of day to be given:** \_\_\_\_\_

**Directions, if to be given "as needed":** \_\_\_\_\_

**Dates medication is to be given:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescribing doctor's name:** \_\_\_\_\_

**Illness or condition prescribed for:** \_\_\_\_\_

**If inhaler or EpiPen, does the youth have to carry on-person and self-medicate?**

Yes \_\_\_\_ or No \_\_\_\_