AMERICAN HERITAGE GIRLS®
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Request for Administration of Medication

Please attach to Health Form and update as necessary
(This form is only valid for 12 months and must be kept on file at the Troop level for at least one year following its date.)

Registered Members are discouraged from taking medication at AHG events unless the medication is needed for a life-threatening emergency or the AHG event occurs over the course of multiple days.

The following section must always be completed by the parent/guardian.

Check all that apply and complete all applicable sections of this form.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Member: _____ Date of Birth: _____ Weight: _____

Name of Medication: _____ Exact Dosage: _____

To be administered at the following times: _____

For the following period of time: _____

Restrictions or any other medications ☐ YES ☐ NO Explain, if yes: _____

_____

A separate form is completed for each medication administered.

☐ I understand my child must receive one dose of medication before arriving at a Troop event (unless the medication is used for emergencies).

☐ I authorize selected Adult Member to administer the above prescription medication as prescribed by my health care provider. If the medication is an over-the-counter medication I authorize its use according to the provided instructions. I authorize the Troop to contact my child's health care provider as needed regarding this medication and/or my child's response.

☐ This is an emergency medication (i.e. inhaler, epi-pen) and must be kept on the person.

Print Doctor's Name: _____ Telephone: _____

Address: _____

Signature of Parent/Guardian: _____ Date: _____

The following section must be completed additionally by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant if any of the following apply:

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication or prescription medication without a prescription label.
4. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of Member: _____

Name of medication, vitamin, diet, supplement: _____

Dosage: _____ Possible side effects: _____

Expiration Date: _____

Instructions: _____

This child is under my care and should receive the above medication as written.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant _____ **Date** _____