



Medication Consent Form and Medication Record

Student's name: _____

In case of emergency, please contact:

Name 1		Name 2	
Phone 1		Phone 2	

It is First Baptist Greenville policy to keep ALL prescription (Rx) and over-the-counter (OTC) medications in a secure place with the designated chaperone. At check-in, parents and participants MUST give all medications to staff and medications MUST be sent in original bottle/container.

Please list all allergies including medication and/or first aid supply allergies:

Please list all information for each medication to be administered by a chaperone during the trip.

Name of medicine	Dose (amount)	Dose (instructions)	Last dose administered?

The following OTC medications (or generic equivalent) are available from a chaperone. Please indicate if you give permission for your student to take these medicines 'as needed' by checking yes or no. Only medicines that are checked 'yes' and determined to be necessary will be administered at the discretion of the chaperone/staff. Administration of these medicines will be per label instructions unless otherwise indicated by your physician.

Tylenol (discomfort/fever)	___ yes	___ no	Visine (eye irritation)	___ yes	___ no
Advil (discomfort/fever)	___ yes	___ no	Milk of Magnesia (constipation)	___ yes	___ no
Throat Lozenges (throat irritation, cough)	___ yes	___ no	Imodium (diarrhea)	___ yes	___ no
Benadryl (allergies)	___ yes	___ no	Mylanta (stomach upset)	___ yes	___ no
Cortizone Cream (skin irritation)	___ yes	___ no	Tums (heartburn/upset stomach)	___ yes	___ no

My child and I have been informed of and understand the following policies regarding the use of 'as needed' medication.

1. Students are responsible for informing a chaperone that they need to take 'as needed' medication.
2. Students may not share ANY medication with other students and may not sell their medication to other students.

Parent/Guardian Name (printed)

Parent/Guardian signature

Date

FOR CHAPERONE USE

Name of medication _____

Date	Date	Date	Date
AM	AM	AM	AM
PM	PM	PM	PM

Name of medication _____

Date	Date	Date	Date
AM	AM	AM	AM
PM	PM	PM	PM

Name of medication _____

Date	Date	Date	Date
AM	AM	AM	AM
PM	PM	PM	PM