

NEW LENOX COMMUNITY PARK DISTRICT
Adventure Club Before & After School
Medication Form

If your child takes medication, please fill out this form in its entirety.

1. Each form of medication **MUST** be in the original container from the pharmacy.
2. The container **MUST** have the **ORIGINAL PRESCRIPTION LABEL**, which includes:
Doctor's name, patient's name, pharmacy, medication, strength, dosage, and date.

Child's Name: _____

Name of Medication: _____

Dosage and Quantity: _____

Prescription Number: _____

Pharmacy Phone Number: _____

Times to be given: _____

Dates to be given: _____

Special Instructions: _____

Doctor's Name: _____

Date last seen by Doctor: _____

I give permission for the New Lenox Community Park District Adventure Club staff to administer medication to my child.

Parent/Guardian Signature

Date