

ADDENDUM TO THE 4-H YOUTH HEALTH FORM

Complete this form if **prescription medications** are being taken by the student at the time of the event or if **over-the-counter medication** is to be administered by a leader or chaperone.

County: _____

4-Her's Name: _____

Address: _____
Street, Route, or Box Number

City State Zip

Phone: Day () _____ Evening () _____

Name of Medication: _____

What Illness/Condition is this medication intended for: _____

Check one of the following:

_____ Tylenol/Ibuprofen may be administered by 4-H Youth Development event personnel

_____ Benadryl may be administered by 4-H Youth Development event personnel

_____ Medication is to be self administered by student

_____ Medication is to be administered by 4-H Youth Development event personnel

Dosage: _____ Refrigeration? Yes _____ No _____

Special Instructions: _____

Other information (if applicable): _____

Date(s) to Administer: From _____ To _____

Prescribing Doctor's Name: _____ Phone: () _____

Note: This form is to be used as a reference for 4-H participants taking any medication (prescription or "over-the-counter"). Administering of the medication is the responsibility of the participant. If health facilities and/or personnel are available at the facility and you prefer the trained personnel to administer the medication you may request this prior to the event.

Event: _____ Date (s): _____

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

Date