Medication Information—Outside of Program Hours

Does your participant take any medications **outside of program hours**? ☐ Yes ☐ No

(Note: EAF needs this information on file in case of a medical emergency)

Name of medication	Time(s) of day medication is administered	Dosage	Method of Administration	Reason for medication	Side effects (if any)	Special Instructions (if any)

I acknowledge and confirm that the above information is correct by signing below.

Participant 's name _____

_____ Date

_____ Parent/Guardian

Medication Information—During Program Hours

Does your participant currently take any medication **during program hours ?** ☐ Yes ☐ No

If yes, please fill out the table below:

Name of medication	Time(s) of day medication is administered	Dosage	Method of Administration	Reason for medication	Side effects (if any)	Special Instructions (if any)

I authorize EAF staff to administer the above medication to _____ and I certify that the instructions given are those recommended by his/her physician.
Print name

_____
Date

_____
Parent/Guardian