

**Complete & Return
by April 10**

MEDICATIONS BEING TAKEN

Please list all medications (including over the counter or nonprescription drugs) taken routinely and **bring enough medication to last the entire time on trip.**

This person takes NO medication on a routine basis.

This person takes medications as follows:

Med # 1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med # 2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med # 3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med # 4 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications or information about side effects if necessary.

RESTRICTIONS

Dietary

Does not eat red meat Does not eat fish Does not eat eggs Does not eat poultry

Does not eat dairy products Other (describe) _____

Comments on dietary restrictions _____

Parent Signature: _____

Parent (PRINTED NAME): _____

*****PLEASE FEEL FREE TO ATTACH LISTS OF MEDICATIONS, INDIVIDUALLY
PURCHASED INSURANCE, OR ANY OTHER SPECIAL INSTRUCTIONS ON A SEPARATE
SHEET IF NECESSARY. *****

*****MEDICAL FORM INFORMATION IS CONFIDENTIAL AND ONLY SHARED WITH
CHAPERONES. FORMS ARE SHREDDED AFTER THE TRIP. *****