Medication Form & Allergy Action Plan

Child's Name: ________________________________ **Date of Birth:** __________ **Grade:** ______

Parent/Guardian Name: ________________________________ **Phone:** ___________________

Emergency Contact Name: ______________________________ **Phone:** ____________________

Asthmatic: ☐ **Yes** ☐ **No**

Allergy to: ____

I, the parent of _________________ (child's name), give permission to the Children's Ministry staff at Christ Church Plano to administer medication as noted below. I will provide the medication in its original container and clearly labeled with the child's name and/or prescription label, in the Children's Ministry office. I understand that any expired medication will be disposed of safely and properly, and I will be notified before such action occurs.

Medication # 1:

Name & Strength (e.g., 5 mg. or 100 ml): ___________________________

Time to be taken: ________________________

Dosage: (# of pills, puffs, tsp., etc.) _________________

Reason for medication: _____________________________________

Medication # 2:

Name & Strength (e.g., 5 mg. or 100 ml): ___________________________

Time to be taken: ________________________

Dosage: (# of pills, puffs, tsp., etc.) _________________

Reason for medication: _____________________________________

Medication # 3:

Name & Strength (e.g., 5 mg. or 100 ml): ___________________________

Time to be taken: ________________________

Dosage: (# of pills, puffs, tsp., etc.) _________________

Reason for medication: _____________________________________

_____________________________________ _____________

Parent/Guardian Signature Date