STRONG NATION
CHURCH

MEDICATION MANAGEMENT FORM

(For under 18's)

(TO BE COMPLETED BY PARENT/GUARDIAN)

Attendee Full Name			
Gender	☐Male ☐Female	DOB	____/____/_____

MEDICATION DETAILS

Medical Condition			
Is your child's condition triggered by any particular factors? Please list.		What symptoms does your child experience during an attack?	
Does your child have a management plan?	☐No ☐Yes (please provide a copy)		
Name of Treating Doctor		Doctors Phone	

Regular/Prescribed Course of Medication		
Name of Medication	Dosage	Frequency/Times
1.		
2.		
3.		
Medication for treatment of an attack/episode		
1.		
2.		
3.		

EMERGENCY CONTACT DETAILS

Full Name		Relation to attendee	
Phone		Date	_____/_____/_____ _
Signature			

On arrival to Forever Free, please hand medication in a sealed ziplock bag to Taliah Clark. Please return ***completed form*** *to admin@strongnation.church OR hand to Taliah Clark on the first day of Forever Free along with your medication.*

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