

Youth Medical Form

Youth Member's Name _____

Due January 20, 2023 to your Extension Office.

County _____

Please place an X in the box below the time when the medication should be administered.

Name of Medication	Dosage (amount to be given)	Breakfast	Lunch	Dinner	Bedtime	As Needed	Reason Taking Medication

Allergies: _____

Food Allergies/Dietary Restrictions: _____

Special Instructions/Concerns/Side Effects or Reactions: _____

Please place an X in the boxes below of what time(s) medication needs to be administered.

_____ receives medication at the following times:

Youth Member Name

Breakfast	Lunch	Dinner	Bedtime	As needed

For Staff Use Only.
Housing: _____