

Martinez MYF

Medication Form

Date: _____

Participant(s) Name: _____

Medications: _____

Dose & Times per day _____

My son/ daughter id allergic to the following foods;

My son/ daughter has the following medical condition:

Statement of understanding:

I understand that while my youth is on this trip, the adults leading he trip Martinez UMC.

Parent/ Guardian Signature: _____

Print Name: _____

Address _____

Alternate Emergency Contact person & phone numbers in case unavailable:
