AMERICAN HERITAGE GIRLS®
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Request for Administration of Medication

Please list all medications currently used, including any over-the-counter medications. If additional medications are added at any time, including short term prescriptions or over-the-counter treatments, please complete an additional or new *Request for Administration of Medication Form*.

Member Name		Troop Number	

Name of medication	Diagnosis or reason the medication is needed	Prescription Medication	Nonprescription Medication	Topical Product or Lotion	Supplement	Refrigeration Required	Emergency medication to be kept on	Dosage	To be administered at the following times:	For the following period of time:	Restrictions or reactions, if any, and necessary emergency response:

If additional medications are needed, please attach additional documentation.

Non-prescription medication administration is authorized with these exceptions:

I authorize the AHG Health and Safety Lead for the meeting, trip, evet or activity to administer the above medications as prescribed by my child's health care provider. If the medication is an over-the-counter medication, I authorize its use according to the provided instructions. If I am unable to be contacted, I authorize the Troop to contact my child's health care provider as needed regarding this medication and/or my child's response.

Parent/guardian signature: _____

MD/DO, NP, or PA signature (if your state requires signature): _____

Date: _____