Florida DeMolay
Medication Usage / Dosage Form

This form is to be completed for the authorized use of medications (including prescriptions).
At no time should a DeMolay or youth visitor dispense their own medication while at a DeMolay function.
This form should be completed shortly after initiation or when the DeMolay / youth becomes involved with DeMolay.
It should be updated or renewed annually and kept on file with the Medical Release & Consent Form.
Any questions should be directed to administration@fldemolay.com.

Youth Name: _____

Chapter: _____ **ID Number:** _____

Youth: Status:
- ☐ **Active DeMolay**
- ☐ **Squire**
- ☐ **Sweetheart / Court**
- ☐ **Youth Visitor**

Date Form was completed: _____

Age of Youth when this was completed: _____

Is the youth allergic to any medications? ☐ **Yes** ☐ **No** **If yes, list:** _____

Over the Counter (OTC) Medications:

Please check "Yes" or "No" to authorize the Advisory Council and/or adult chaperones to administer the following OTC medications to your child. OTC medications will be dispensed per package dosing instructions unless otherwise specified. Generic medications may be substituted per availability.

OTC Medication	Indications	Yes	No
Tylenol (Acetaminophen)	Pain reliever / fever reducer		
Advil / Motrin (Ibuprofen)	Pain reliever / fever reducer		
Midol	Menstrual cramp relief		
Benadryl	Allergies / congestion		
Sudafed	Nasal / sinus congestion		
Cough Drops / Lozenges	Cough / throat irritation		
Other:	Other:		

Medically Prescribed (RX) Medications:

Prescription Medication: _____ Dose: _____

Dosage Instructions (time, frequency): _____

How provided? ☐ Liquid ☐ Tablet ☐ Capsule ☐ Injection ☐ Other: _____

Description of Medication: Color: _____ Shape: _____

Does it require refrigeration? ☐ Yes ☐ No Date Medication Started: _____

Indication for Medication: _____

Parental Consent

In addition to the personal information I have provided regarding my child on his/her Medical Release & Consent Form, I attest that the above information is accurate, and that I consent to my child's continued participation in DeMolay activities.

Parental Signature: _____ Cell Number: _____

******Additional copies of this form may be used for multiple prescriptions, as needed.******