

PART III: Permission to Dispense Prescription Medication (*If not completed, Young Marines will not receive medication*)

I request and authorize that my child, _____, be administered the following prescription medication:

_____ per the medical doctor's instructions on the original and un-expired pharmacy label. I certify that my child has a valid health reason for taking the medication during the Young Marine Activities. This permission is valid from (beginning date) _____ to (ending date) _____.

Parent or Legal Guardian _____ Date _____

PART IV: Medication Administration Record

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____