

# DFUMC MEDICINE RELEASE FORM

STUDENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Please list all prescription medication:

MEDICATION	DOSAGE	FREQUENCY

I give DFUMC/DAP staff to administer over the counter medications to my child id he/she needs it. \_\_\_\_yes \_\_\_\_no

Parent Signature \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Date signed: \_\_\_\_\_