OUTDOOR ADVENTURES & WHEELCHAIR SPORTS PROGRAM

Trip Medication Form

NAME: _____
DATE OF BIRTH: _____

TRIP DATES: _____
Trip Name: _____

NAME OF MEDICATION	DOSAGE	TIME OF DAY ADMINISTERED	PURPOSE	TYPE OF ASSISTANCE NEEDED

Casa Colina staff will assist with administration of oral medication to the degree necessary. Participant assumes responsibility for assuring that medications are taken at scheduled times. Medications must be in original bottle/container from the pharmacy, the label must have participant's name and may not be expired. Casa Colina staff will not assist with injections.

Through my signature below, I attest that I have listed all of the medications above accurately and completely.

Signature of
Participant:_____Date:_____

Signature of Parent or Legal Guardian for Minors_____Date:_____
or Participant's Legal Representative if Applicable