Special Olympics Connecticut

MEDICAL INFORMATION FORM

AUTHORIZATION FORM FOR MEDICATION ADMINISTRATION

BY SOCT MEDICAL PERSONNEL

NAME OF ATHLETE: _____

ADDRESS: _____

D.O.B.: _____

MEDICATION LIST

NAME OF MEDICATION	DOSAGE	TIME OF ADMINISTRATION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIES **YES** **NO**
IF YES, PLEASE LIST _____
_____

NAME OF PHYSICIAN _____

PHYSICIAN'S TELEPHONE _____

EMERGENCY CONTACT NAME _____

EMERGENCY CONTACT PHONE _____

SIGNATURE OF PARENT OR RESPONSIBLE PERSON **DATE**