MURRAY SPECIAL OLYMPICS - OVERNIGHT TRAVEL MEDICATION LIST

MEDICATION LIST – If no meds are taken please complete and write NONE in the medication section.

Date:_____ _____

ATHLETE NAME:_____

EMERGENCY CONTACT:_____. CONTACT PHONE #: _____

OVER THE COUNTER MEDICATION	**DOSAGE**	**TIME OF DAY TO BE TAKEN**
PRESCRIPTION MEDICATION	**DOSAGE**	**TIME OF DAY TO BE TAKEN**

- ❑ Athlete is responsible for taking his/her own medication
- ❑ Athlete needs assistance or reminders when taking his/her medication: **If athletes need assistance please pack medication in baggies marked for each dose (ex. Fri pm, Sat am, Sat pm, Sun am). Please send the original pill bottle for medical reference in case an emergency occurs. Please do not use the pill boxes with the days of the week as we have had those pop open in luggage and not known what pills are to be taken.**
- ❑ Allergies: (list)_____
- ❑ Symptoms of allergic reaction: _____
- ❑ No Known Allergies
- ❑ Seizures: No _____ Yes _____ Date of last seizure: _____
  Please list below steps to be taken during & after a seizure.

Please list any information/comments you would want medical professionals to know if an emergency were to occur and for some reason your athlete was unable to speak for him/herself.

_____

_____

_____

Signature: _____