ADAPTABILITIES
CREATING SUCCESS FOR LIFE

Medication Release

Participant Name: ____

Name of Parent/Guardian ____

☐ If no medication is required, sign below

List medications administered by AdaptAbilities, including non-prescription medications (ie: over-the-counter and herbal remedies.)

Medications to be returned:	◯ Daily		◯ Weekly		◯ Monthly
Medication Name					
Prescription?	☐ Yes ☐ No	Time(s):		Dosage:	
Side Effects:					
Instructions:					
Medication Name					
Prescription?	☐ Yes ☐ No	Time(s):		Dosage:	
Side Effects:					
Instructions:					
Medication Name					
Prescription?	☐ Yes ☐ No	Time(s):		Dosage:	
Side Effects:					
Instructions:					
Medication Name					
Prescription?	☐ Yes ☐ No	Time(s):		Dosage:	
Side Effects:					
Instructions:					
Medication Name					
Prescription?	☐ Yes ☐ No	Time(s):		Dosage:	
Side Effects:					
Instructions:					

Signed this ____________ day of _____________, 20_____, Edmonton, Alberta

Individual/Guardian/Primary Contact ________________ Signature: Individual/Guardian/Primary Contact ________________

Reviewed by: Staff Name ________________ Staff Signature ________________

compassion • belonging • capacity building • integrity • peace of mind • teamwork