MEDICATION RELEASE

Participant Name: ____

Name of Parent/Guardian: ____

☐ **I DO NOT Take Medication** (signature required)

List medications administered by AdaptAbilities ONLY, including non-prescription, over-the-counter, and herbal remedies. All medications must have a pharmacy label.

Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		

Signed this ______ day of __________________________, 20______, Edmonton Alberta expiring August 31, 2023.

______________________________________ Individual/Guardian/Primary Contact Name

______________________________________ Individual/Guardian/Primary Contact Signature

______________________________________ Reviewed By: Employee Name

______________________________________ Employee Signature

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