ADAPTABILITIES
CREATING SUCCESS FOR LIFE

# MEDICATION RELEASE

Participant Name: ___________________________________________________________

Name of Parent/Guardian: _____________________________________________________

Medication Release form required for participants who require medications to be administered by AdaptAbilities ONLY, including non-prescription, over-the-counter, and herbal remedies. All medications must have a pharmacy label.

| Medication Name | | Prescription? | ☐ Yes<br>☐ No | Return to Family |
|---|---|---|---|---|
| Side Effects: | | Time(s): | | ☐ Daily<br>☐ Weekly<br>☐ Monthly |
| Instructions: | | Dosage: | | |
| Medication Name | | Prescription? | ☐ Yes<br>☐ No | Return to Family |
| Side Effects: | | Time(s): | | ☐ Daily<br>☐ Weekly<br>☐ Monthly |
| Instructions: | | Dosage: | | |
| Medication Name | | Prescription? | ☐ Yes<br>☐ No | Return to Family |
| Side Effects: | | Time(s): | | ☐ Daily<br>☐ Weekly<br>☐ Monthly |
| Instructions: | | Dosage: | | |
| Medication Name | | Prescription? | ☐ Yes<br>☐ No | Return to Family |
| Side Effects: | | Time(s): | | ☐ Daily<br>☐ Weekly<br>☐ Monthly |
| Instructions: | | Dosage: | | |
| Medication Name | | Prescription? | ☐ Yes<br>☐ No | Return to Family |
| Side Effects: | | Time(s): | | ☐ Daily<br>☐ Weekly<br>☐ 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 •