COMMONWEALTH CHALLENGE YOUTH ACADEMY

Medical Prescription Form

Cadet Last Name:	Cadet First Name:	MI:	DOB:

Custodial Parent(s): Please provide this form to your child's treating physician to verify current prescription(s) and over the counter medication(s) that my child may need during the duration of the program. As custodial parent(s) of the above name minor, I understand that I/we are personally responsible for having the following prescription(s) and over the counter medication verified by the treating physician. ***Only*** prescription and over the counter medications approved by the treating physician will be stored and dispensed to your child.

Custodial Parent Signature:_____ **Date:**_____

To Treating Physician: The above name individual is enrolling in the COMMONWEALTH CHALLENGE YOUTH ACADEMY program, which is a **5 ½ month program beginning on Oct 3rd, 2016**. As the authorized treating physician, please outline any and all prescription and over the counter medications that can be dispensed to the cadet. So that the medication schedule is not interrupted, please identify the time frame the medication must be dispensed and when applicable, provide enough refill medication to cover the duration of the program.

***Dispense Schedule**: **AM:** 7am –8am, **PM:** 12pm-1pm, **HS:** 8pm-9pm. **Other (O):** If the medication MUST be given outside of the normal dispensing schedule, please place the exact time the medication must be given. Otherwise, please try to adhere to the Challenge Medical clinic's dispensing schedule.

Medication Brand Name/Generic	Mg	Dose	Freq	Dispense Schedule *circle approved time	Reason
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
OTC Medication	**Mg**	**Dose**	**Freq**	AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	
				AM / PM / HS / O:___	

As the treating physician for the above named Cadet, I have outlined the approved prescription and over the counter medication(s) which can be dispensed during the duration of the program. I have also provided adequate prescription refill(s) to cover the duration of the program or have outlined below, requirements before a medication can be re-filled.

Comments:_____

_____

Treating Physician Name:_____ **Signature:**_____ **Date:**_____

Facility/Practice Name:_____ **Phone:** _____

Form must be completed and returned to Challenge's Medical Department by August 26, 2016. Please fax form to: 757-223-7939 or email: Challenge@tmd.bz