City of Torrance Community Services Department ● RECREATION SERVICES DIVISION
310/ 618-2930 ●WWW.Recreation.TorranceCA.Gov

Participant Health Form/Medication Form

I. TO BE COMPLETED BY LICENSED PHYSICIAN

_____ _____ _____
Last Name First Name Sex School

Diagnosis/Purpose of Medication(s): _____
_____

_____

Name of medication(s): _____

_____

Dosage prescribed: _____

_____

Length of time medication will be necessary: _____
_____

Possible side effects: _____
_____

Action to be taken in case of side effects: _____
_____

Special instructions: _____
_____
_____

I verify that this student is under my care and requires this medication.

_____ _____ _____
Print Name Signature Date

_____ _____
Street Address City State Zip Code

_____
Telephone

II. TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child _____, be given access to his/her medication at the requested time. If this request is granted, I agree to hold the City of Torrance Community Services Department harmless in providing this service to my child. I hereby give consent to the Community Services Department staff.
I _____hereby agree to the above stated contract.

_____ _____
Signature Date

"Creating and Enriching Community through People, Programs and Partnerships"

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CENTRALLY STORED MEDICATION

FACILITY NAME
SPECIALIST
SUPERVISOR

INSTRUCTIONS: Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each participant.

NAME (LAST) (FIRST) (MIDDLE)	ADMISSION DATE	ATTENDING PHYSICIAN

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STORED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO OF REFILLS	NAME OF PHARMACY

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