Boys State City_____

MEDICATION INFORMATION

IF TAKING PRESCRIPTION MEDICATIONS PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU TO HAND IN AT REGISTRATION CHECK-IN ON JUNE 23, 2024.

Delegate Name:_____ Parents Name:_____

Date of Birth:_____ Parents Home Phone #:_____

Address: _____ Parents Cell #:_____

_____

_____

Allergies:

_____
_____
_____
_____
_____

Name of Medication:	**Dosage**	**Frequency**	**Time of Day**