Cooperative Extension Service

Kentucky 4-H Medication Form 2025

Participant's Name	County	Sleeping Facility	Age	Weight

	Name of Medicine	Dosage	Time of Medicine (Check all that apply)					Notes (e.g., as needed, take w/ food)
			Breakfast	Lunch	Dinner	Bedtime	Other	
1								
2								
3								
4								
5								
6								

DIRECTIONS:

Place the following items in a clear bag: (1) medications in original containers, and (2) this completed form. On the outside of the bag write (with a permanent marker) the participant's name.

Event Coordinator or Agent Use Only:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Notes if needed
Breakfast								
Lunch								
Dinner								
Bedtime								
Other								
As needed								