**Please return this form by May 17, 2019.**

**Upload a scanned copy to:**

[**https://HOBY.formstack.com/forms/medication\_verification\_form\_upload**](https://hoby.formstack.com/forms/medication_verification_form_upload)

 **Or mail the form to:**

*Hugh O’Brian Youth Leadership — Texas Gulf Coast Seminar*

*2910 Randolph, Pasadena, TX 77503*

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Medication Verification Form for Physicians

**(Please type or print legibly)**

**(This form is to be completed by the participant’s prescribing physician. If the participant has more than one**

**prescribing physician, then each physician will need to complete a form. Please type or print legibly.)**

1. Name of Participant/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Prescribing Physician Name:
3. Prescribing Physician Medical License Number and State where licensed:
4. Please complete the chart below for the medications which you have prescribed to the participant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Type of Medication | Condition for Treatment | Dosage | Frequency |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Please affix physician’s business card or voided prescription in the space below.

As the prescribing physician, I attest that the use of the medications prescribed by me, and taken as directed as listed above, should not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

**⌦** **Signature of Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**