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**Please return this form by May 17, 2019 to:**

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

*P.O. Box 590928*

*Houston, TX 77259*

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.

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