HOBY HUGH O'BRIAN YOUTH LEADERSHIP	**Please return this form by May 1, 2019 to:** HOBY Wisconsin P.O. Box 1397, Kenosha, WI 53141 info@wisconsinhoby.org

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

5. 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: ______________