Camper Medication Form

Camper Name: _____ Dates Attending: _____

Medications

Medication and reason for use (ie: Amoxicillin for ear infection)	Dosage and frequency (ie: 1 pill, 3x/day)	Check all that apply Sunday - Saturday
	□ Or as needed	□ Breakfast □ Lunch □ Dinner □ Bedtime
	□ Or as needed	□ Breakfast □ Lunch □ Dinner □ Bedtime
	□ Or as needed	□ Breakfast □ Lunch □ Dinner □ Bedtime
	□ Or as needed	□ Breakfast □ Lunch □ Dinner □ Bedtime

For STAFF use only

Staff be sure to initial EVERY time you distribute medications.

Medication	Time	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1.	Bfast							
	Lunch							
	Dinner							
	Bedtime							
2.	Bfast							
	Lunch							
	Dinner							
	Bedtime							
3.	Bfast							
	Lunch							
	Dinner							
	Bedtime							
4.	Bfast							
	Lunch							
	Dinner							
	Bedtime							