Camp Horseshoe Troop Medication Records

Name of camper: _____ Dates attending camp: _____ to _____

Allergies_____

Name of Parent/Guardian_____Relationship to patient_____

Phone Number: Home _____Work _____ Cell_____

Please fill out one section for each medication to be administered at Camp. This form should be completed for anyone who will be staying overnight at camp. This includes scouts and adults who need to take medication while at Camp Horseshoe.

All medications should be in the original container with the original label prepared by the pharmacy or physician which provides all of the customary information such as the patient's name clearly marked, drug name, dosage and instructions. All non-prescription medication must be marked with the patient's name and any instructions.) WE ASK THAT THIS FOFM BE COMPLETED BY THE PARENT OR GUARDIAN AND TURNED IN TO THE TROOP LEADERSHIP BEFORE THE START OF THE SCOUT'S CAMPER WEEK.

All medications (except Epic pens, Lactaid and albuterol inhalers) must be turned in to the Troop Leaders at the start of the patient's stay in camp.

EPIPENS AND RESCUE INHALERS should be carried by the scout at all times while at camp, in accordance with the prescription or instructions from the patient's physician.

List of all campers taking medication to reconcile against individual medication administrating record(s) found below.

NAME	NAME	NAME

Name of Scout _____ **Troop**_____

Medication name/ Strength:

When medication is to be taken (e.g. after breakfast every day):

Other specific instructions (e.g. needs to be taken after eating):

Time:	Breakfast	Lunch	Dinner	Bedtime
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Signature of Parent/Guardian _____ **Date:** _____

Name of Scout _____ **Troop** _____

Medication name/ Strength:

When medication is to be taken (e.g. after breakfast every day):

Other specific instructions (e.g. needs to be taken after eating):

Time:	Breakfast	Lunch	Dinner	Bedtime
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Responsible Troop leader will initial in the appropriate box when medication is administered.

Signature of Parent/Guardian _____ **Date:** _____

Name of Scout _____ **Troop** _____

Medication name/ Strength:

When medication is to be taken (e.g. after breakfast every day):

Other specific instructions (e.g. needs to be taken after eating):

Time:	Breakfast	Lunch	Dinner	Bedtime
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Responsible Troop leader will initial in the appropriate box when medication is administered.

Signature of Parent/Guardian _____ **Date:** _____

Name of Scout _____ **Troop** _____

Medication name/ Strength:

When medication is to be taken (e.g. after breakfast every day):

Other specific instructions (e.g. needs to be taken after eating):

Time:	Breakfast	Lunch	Dinner	Bedtime
Sunday				
Monday				
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Responsible Troop leader will initial in the appropriate box when medication is administered.

Signature of Parent/Guardian _____ **Date:** _____