Camp Use Only

Check Labels _____
Reviewed Schedule _____
Parental Signature _____
Counselor List _____

Name: _____ _____
First **Last**

Bunkhouse: _____

Dates: _____

All prescription medications MUST be in correctly labeled container with name and dosage.

Medications

If your child's name is not on your non prescription container, please write it on it.

Medication and reason for use (Example: Amoxicillin for ear infection)	Dosage and Frequency (Example: 1 Tablet 3x/Day)	X All that apply	FOR NURSE USE ONLY
		☐ 8:30 AM (or _____) ☐ 1:00 PM (or _____) ☐ 6:30 PM (or _____) ☐ 9:00 PM (or _____) ☐ As Needed prn	SU M TU W TH F S
		☐ 8:30 AM (or _____) ☐ 1:00 PM (or _____) ☐ 6:30 PM (or _____) ☐ 9:00 PM (or _____) ☐ As Needed prn	SU M TU W TH F S
		☐ 8:30 AM (or _____) ☐ 1:00 PM (or _____) ☐ 6:30 PM (or _____) ☐ 9:00 PM (or _____) ☐ As Needed prn	SU M TU W TH F S
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		☐ 8:30 AM (or _____) ☐ 1:00 PM (or _____) ☐ 6:30 PM (or _____) ☐ 9:00 PM (or _____) ☐ As Needed prn	SU M TU W TH F S
Allergies or Special Medical Conditions			Nurse's Notes

Parent or Guardian Signature _____

Nurse Signature _____

Parents Address: ---------- ----------

Parents Phone/cell # _____