Camper Medication Form

Print Camper Name: ____

Camp Duration: ☐ 21 Days ☐ 28 Day

ALL medications **MUST** be in original packaging. Please **DO NOT** take your camper off their medications or make drastic changes to their protocol during camp.

Medication and reason for use (ie: Amoxicillin for ear infection)	Dosage and frequency (ie: 1 pill, 3x/day)	Check all that apply
	☐ 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

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							