

Camper Name:	Age:	Camp:
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Bring camper's medications in the original prescription bottle placed in a ziplock bag with camper's first and last name written with sharpie marker on the ziplock bag. For all Prescription medications, please only send enough for the days at camp.

Medication Information:						
<input type="checkbox"/> This camper <u>will not</u> take any daily medications while attending camp						
<input type="checkbox"/> This camper <u>will take</u> the following daily or as needed medications while at camp:						
Name of Medication:	Reason for Taking:	Times Given:	Dose Given:	How is the dose given?	Fill Count	Initials:
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	In:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	Out:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	In:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	Out:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	In:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	Out:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	In:	
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Tab/Liquid <input type="checkbox"/> Dissolvable <input type="checkbox"/> Injection <input type="checkbox"/> Other:	Out:	