

Pathways 2010

CAMPER MEDS

Camper Name: _____

Medications	Dosage	Time Given	Reason

Please list all medications taken routinely. Be sure to provide enough medication to last the camper the entire time while at camp. It should be kept in the original container, or packaging, that identifies the prescribing physician, who the medicine is intended for, the name of the medication, the dosage, and the frequency of administration.

Signature of parent or legal guardian _____

THIS FORM IS TO BE SUMITTED TO THE CAMP HEALTH CARE PROFESSIONAL WITH ALL CAMPER MEDICATIONS UPON THE DAY OF ARRIVAL AND REGISTRATION

Office Use Only:

Dorm _____

Verification notes (if needed):