Camp Medication Form

Child's Name: ________________________

Grade Level: _______________

Allergies: ____________________________

Please list ALL medications in table below:

Medication Name	**Dosage**	**When** (Breakfast, Lunch, Dinner, Bedtime, or as needed)	**Other Comments:** (Please indicate if this is an emergency medication)

Will the student be carrying their own medication and be held responsible for administering it to themselves? _____Yes _____No

I authorize the administration of over-the-counter medications to my child if deemed necessary by camp nurse. ____Yes ____No

Parent/Guardian Signature: __________________________

Date: ____________