



Administration of Prescription & Non-Prescription Medication to a Camper

(To be completed by Parent/Guardian)

CAMP(S) YOU ARE ATTENDING: _____

NAME OF CAMPER: _____

NAME OF PARENT/GUARDIAN: _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

EMERGENCY #: _____ NAME _____

FOOD/DRUG ALLERGIES: _____

Please list ALL medications (including over-the-counter or non prescription drug) taken routinely. Bring enough medication to last the entire time at camp. Keep original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration

Non-Prescription Medication

Yes No

Allowed to take "over the counter" medications during camp stay (Advil, Tylenol, Tums, etc.).

Prescription Medication

Yes No

Prescription Medications will be taken during camp stay. Please list each drug separately in the boxes below (This includes inhalers/epi pens).

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements: _____

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements: _____

Name of Medication: _____

Dose given at Camp: _____ (i.e. 1x/day, 2x/day) Duration of Order: _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements: _____

In accordance with the 105 CMR 430.160 of the MA Dept. of Health

Parent/Guardian Signature & Date

Physician's Signature & Date