

MEDICATION ADMINISTRATION RECORD 2

-Prescription Medication-

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Parents/ Guardians: Please fill in medication information in blocks on left only. **Medications must be in original container with doctors directions if it is prescription (please no pills in bags or daily dispens-ers).** Please place medications into a sealable plastic bag that is clearly labeled with you campers name, date of birth, and allergies written in permanent marker on the out-side of the bag. Please send inhaler if your child has asthma. Please send Epi-Pen if your child has a history of severe allergic reactions.

Parents/Guardians: The medication, dosage, and frequency to the left are for you to fill out.

Authorized Camp Staff: The date and time blocks to the right are for you to chart when medication was **self-administered** and supervised.
 (Missing Dose ey: R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	Dose	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	
Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments: _____

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments: _____

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments: _____

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments: _____

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments: _____

Authorized Prescriber Signature: _____ **Date:** _____

Medication Administration Record 3 - Over The Counter (OTC) Medication -

Camper Name: _____
First Middle Last

Birth Date: _____
Month/ Day/ Year

Parents/ Guardians: Please fill in medication information in blocks on left only. Please place **UNOPENED** medications **in Original Containers** into a sealable plastic bag that is clearly labeled with you campers name, date of birth, and allergies written in permanent marker on the out- side of the bag.

Parents/Guardians: The medication, dosage, and frequency to the left are for you to fill out.
Authorized Camp Staff: The date and time blocks to the right are for you to chart when medication was **self-administered** and supervised.
 (Missing Dose Key: R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	Dose	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	
Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments:

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments:

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments:

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments:

Medication: _____	Breakfast							
_____	Lunch							
Dosage: _____	Dinner							
_____	Bed							
Frequency: _____								

Comments:

Authorized Medical Professional: _____ Date: _____