Medication Administered Log

Week: _____

Cabin: _____

Circle: AM Noon Dinner HS PRN

Counselor _____

(Swamp Nurse use only)

Camper Name:

_____

Drug/Food Allergies:

_____

Type of Medication _____ Dose _____ Frequency _____

1. _____

2. _____

3. _____

4. _____

5. _____

Special Instructions/Other Medical Concerns:

_____

_____

_____ _____ _____

Parent's Name (print clearly) Date Signature

Verification Medications Administered (completed by Camp Medical Staff)

Sunday _____P.M.

Monday _____A.M. _____Noon _____Eve _____ P.M.

Tuesday _____A.M. _____Noon _____Eve _____ P.M.

Wednesday _____A.M. _____Noon _____Eve _____ P.M.

Thursday _____A.M. _____Noon _____Eve _____ P.M.

Friday _____A.M. _____Noon _____Eve _____ P.M.

Saturday _____A.M.

Camp Medical Staff: Once the medication is administered, note above; print and sign name below:

_____ _____ _____

Staff Name (print clearly) Date Signature

_____ _____ _____

Staff Name (print clearly) Date Signature