Medication Administration Form

GLISSON

Week # ____________ Camper Name ____________________________________ Cabin ___________ Counselor Name __________________________

Parents Complete		For Use By Glisson Healthcare Team																											
	Date																												
Please list only the medications to be taken at camp	Day of the Week	SUNDAY				MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY			
	Time	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS
Name of Medication:	**Dosage Amount:**																												
Circle all times to be administered: **Breakfast - Lunch - Dinner - Bedtime - As Needed**																													
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Medication Administration Signature/Initial: ______________________/________ ______________________/________ ______________________/________ ______________________/________

Medication Administration Release

- I attest that the information given in the above "Camper Medication Record" is accurate and truthful.

- I understand that all medications for my Outpost Camper (if enrolled in the Outpost Program) will be administered by an Outpost Staff Member and that the camp nurse will serve Outpost in a consultative or emergency role only.

Parent/Legal Guardian Signature ____ Date ________/________/_________

Parent/Legal Printed Name ____ Phone _________________________

_________________________________ Camper Name

Rev. 04/04/2023 WR