

# MEDICATION ADMINISTRATION FORM



Camper Name: \_\_\_\_\_

Rising Grade: \_\_\_\_\_ (upcoming school year)

Program (circle one): Village | Outpost | Sparrowwood

↓ PARENTS COMPLETE ↓

↓ FOR USE BY GLISSON HEALTHCARE STAFF ONLY ↓

Date Day Time	DATE:				DATE:				DATE:				DATE:				DATE:				DATE:										
	SUNDAY				MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY						
	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	B	L	D
Name of Medication:		Dosage Amount:																													
Circle all times to be administered																															
Breakfast - Lunch - Dinner - Bedtime - As Needed																															
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Staff Medication Administration Signature/Initial: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Parent/Guardian Medication Administration Release:**

- I attest that the information given in the above "Camper Medication Record" is accurate and truthful.
- I attest that all prescription medications to be administered at camp have been packaged by a licensed pharmacist with prescription labels attached.
- I understand that vitamins and supplements are not administered at camp unless prescribed by a physician.
- **Additional item for Outpost program:** I understand that all medications for my Outpost camper 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 \_\_\_\_\_

Parent Phone \_\_\_\_\_

Camper Name