



REQUEST TO GIVE MEDICATIONS

Name: _____ Cabin: _____

Counselor: _____

() **Parent: Check here if camper needs medications on Sunday Evening.**

List any acute or chronic medical or health problems the camper has, including the physician's diagnosis.

- 1. _____
- 2. _____
- 3. _____

SCHEDULED MEDICATIONS:

I request that the designated Camp Frederick staff give my child the following medications and/or treatments as indicated.

Drug Name	Dosage Schedule (Circle below)	Other
1. _____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
2. _____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
3. _____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
4. _____	1x 2x 3x 4x 8am noon 5pm 9pm	_____

AS NEEDED ONLY MEDICATIONS:

Drug Name	Dosage	Reason	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSTRUCTIONS: Place all medications in a paper or plastic bag marked with the camper's name and cabin. Each medication container must be labeled with the camper's name and the name of the medication.

Signature: _____

Relationship to the camper: _____

STAFF USE ONLY

Please initial in the appropriate Day/Time Box for Medications/Treatments.

MEDICATION/TREATMENTS	SCHED	SUN	MON	TUES	WED	THURS	FRI
1.	8 AM						
	12 PM						
	5 PM						
	9 PM						
2.	8 AM						
	12 PM						
	5 PM						
	9 PM						
3.	8 AM						
	12 PM						
	5 PM						
	9 PM						
4.	8 AM						
	12 PM						
	5 PM						
	9 PM						

NAME: _____ INITIALS: _____
 NAME: _____ INITIALS: _____
 NAME: _____ INITIALS: _____