Exceptional Citizens Week Infirmary Medication Sheet

DO NOT MAIL THIS FORM - MUST BE GIVEN TO NURSING STAFF AT CHECK IN

For camp use only, please leave blank

Cabin: _____

Counselor: _____

Camper's Name: _____

Age: _____ Height: _____ Weight: _____

Primary Emergency Contact: _____ Relation to Camper: _____

Phone (Cell): _____ Phone (Home): _____

Secondary Emergency Contact: _____ Relation to Camper: _____

Phone (Cell): _____ Phone (Home): _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Last Hospitalization: _____ **Number of days:** _____ **None**

ALLERGIES & REACTIONS (Medication, Food, and Other):						
Special Diet	**Celiac**	**Dairy Free**	**Egg Free**	**Gluten Free**	**Puree**	**Thicken**

Current Medications:

Name of Medication	Dose	Time Taken (*Please Circle*)				Indication for Use
		AM 8	Noon 12	PM 5	Bed 9	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	
		AM	Noon	PM	Bed	

As Needed Medications (Prescription or Over the Counter):

Name of Medication	Dose	Timing	Indication for Use	Date of Last Use

→ PLEASE SEE THE OTHER SIDE OF THIS FORM FOR ADDITIONAL INFORMATION AND SIGNATURES.

If Camper is on Seizure Medication:

HX of seizure disorder: _____	Warning signs before seizure: _____
Date of last seizure: _____	How seizures should be managed: _____
Known triggers: _____	Medications to be given during a seizure (if any): _____

Please add any additional information here

I certify that the information provided above is accurate as of the date of signing. I authorize the medical staff at camp to administer all listed medications as prescribed.

Parent/Guardian Signature: _____ **Date:** _____

Primary Care Physician: _____ Office Number: _____

MD Signature: _____ Date: _____

Nursing Notes

For camp use only

All medications were administered as written: _____ Date: _____