ACTIVATE - kids camp MEDICAL PRESCRIPTION FORM

Camper's Name_____ Age Weight_____

Church_____

(make extra copies if more than 4 medications are required) Parent's Signature_____

This box to be completed by camp staff:

Dorm & Rm# _____ Counselor _____

Nurse Initials _____ Printed Name _____ Signature _____

PARENT Please Complete:			NURSE completes:									
Medication	Check when to be given		Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:		Day 5 Date:	
			Clock	Int	Clock	Int	Clock	Int	Clock	Int	Clock	Int
Dosage		Breakfast										
		Lunch										
Reason/Special Instructions		Dinner										
		Bedtime										
		As Needed										
Medication	Check when to be given		Day 1		Day 2		Day 3		Day 4		Day 5	
			Clock	Int	Clock	Int	Clock	Int	Clock	Int	Clock	Int
Dosage		Breakfast										
		Lunch										
Reason/Special Instructions		Dinner										
		Bedtime										
		As Needed										
Medication	Check when to be given		Day 1		Day 2		Day 3		Day 4		Day 5	
			Clock	Int	Clock	Int	Clock	Int	Clock	Int	Clock	Int
Dosage		Breakfast										
		Lunch										
Reason/Special Instructions		Dinner										
		Bedtime										
		As Needed										
Medication	Check when to be given		Day 1		Day 2		Day 3		Day 4		Day 5	
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		Lunch										
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