Medication Form

Due 2 weeks before camp

P.O. Box 36, Como, CO 80432
Email camp@campcomo.com
Fax 719-836-0461

Camper Name ______________________________

Dates Attending Camp ______________________________

Church Registered With ______________________________

THIS FORM IS REQUIRED REGARDLESS IF CAMPER BRINGS MEDS TO CAMP. PLEASE WRITE, "NONE" ACROSS THE FORM IF APPLICABLE.

CAMP PERSONNEL TO COMPLETE

Circle one: Camper Adult Faculty TLC Staff

Age __________ Allergies ______________________________

* Indicates rescue inhaler was checked in & person is allowed to carry with them.

NOTES:

CAMP MEDICAL STAFF SIGNATURE:

X

PHYSICIAN/CNP MUST LIST ALL MEDICATIONS BELOW, *INCLUDING OTC, VITAMINS, HERBS, HOMEOPATHICS, ETC.*

Rx

Med:	
Dosage:	Route:
Start Date:	End Date:
Treatment for:	
Contra indications:	

CAMP PERSONNEL

→	SUN	MON	TUE	WED	THU	FRI	SAT
B							
L							
D							
HS							
PRN							

→ Beginning count of medication = Ending count of medication =

Remaining meds were give to ______________________________ at checkout.

PRESCRIBING PHYSICIAN/CNP'S SIGNATURE:

X Date Phone ( )

Printed Name Address City State Zip

Rx

Med:	
Dosage:	Route:
Start Date:	End Date:
Treatment for:	
Contra indications:	

CAMP PERSONNEL

→	SUN	MON	TUE	WED	THU	FRI	SAT
B							
L							
D							
HS							
PRN							

→ Beginning count of medication = Ending count of medication =

Remaining meds were give to ______________________________ at checkout.

PRESCRIBING PHYSICIAN/CNP'S SIGNATURE:

X Date Phone ( )

Printed Name Address City State Zip

PARENT/GUARDIAN'S SIGNATURE:

X Date Printed Name

Please use additional forms if necessary.

Rev. 1/17