CAMP COMO

# 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.***