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 _____

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.