STUDENT / LEADER MEDICATION FORM

ALL students / leaders must complete this form

(confidential for medical provider / emergency use only)

LAST NAME: _____ FIRST NAME: _____

AGE: _____ DATE OF BIRTH: _____

CHURCH: _____

PLEASE DO THE FOLLOWING:

1. Write the **NAME** of the medication or supplement being taken in the **MEDICATION/SUPPLEMENT** column.
2. Write how **OFTEN** it is taken daily in the **DIRECTIONS** column.
3. **LEAVE** daily gray columns **BLANK**; this is for the nursing staff to use each day at camp.
4. **PLEASE DO NOT** send any loose medications or vitamins. **ALL PRESCRIPTION & NON-PRESCRIPTION** medications **MUST** be in original containers. All prescriptions must have patient name and dosage amount on containers.

Medication / Supplement	Directions	Thurs	Fri	Sat	Sun	Mon

Recent illnesses / injuries: _____

History of trouble with: (please circle) Migraines Seizures Asthma Heart Issues Diabetes Other

Please explain any circled: _____

Allergies: Tree Nuts Peanuts Gluten Dairy Hay Fever Bee Stings Other/Meds: _____

Symptoms of allergic reaction: _____

Treatment: _____

If anaphylactic, do you give EPI first or Benadryl? _____

Head injuries: Concussions 1 2 3 4 When _____ Where _____

My child may receive over the counter medicine (i.e. Benadryl, Tylenol, Ibuprofen, Cough Drops, etc.) from the camp nurse. Yes No Exceptions: _____

Emergency Contact: _____ **Phone:** _____

Relationship to you: _____ **Alternate Phone:** _____

Home Address: _____

PARENT SIGNATURE: X _____ **DATE:** _____