



Camper Name: _____

Camp Fire Camp Toccoa Fall Fling

Medication Administration Record

On the table below please list your child’s medication by name (using the name on the prescription bottle), and the required dosage. Note that Camp Fire Camp Toccoa personnel can only administer the dosage as prescribed on the bottle. In the “time given” column circle the time your child should receive their medication as prescribed on the bottle. **Please select “BR” for Breakfast, “L” for lunch, or “BT” for bedtime.**

Prescription medication must be received in its original container. Only the exact dosage required for your campers stay will be accepted.

Upon check in the parent/guardian must turn in this completed form along with the prescribed medication to the Camp Fire Camp Toccoa staff. Medicine should not be stored in the camper’s luggage.

Our house of health is stocked with over the counter medicine (aspirin, Benadryl, Tums, etc.). Due to our existing supply we will not accept any of these medications from home. All inhalers, epi pens, etc. *must* be labeled with the camper first and last name.

Please select “BR” for Breakfast, “L” for Lunch, or “BT” for Bedtime.

Medication Name/Dosage:	Time Given: BR L BT
Medication Name/Dosage:	Time Given: BR L BT
Medication Name/Dosage:	Time Given: BR L BT
Medication Name/Dosage:	Time Given: BR L BT
Medication Name/Dosage:	Time Given: BR L BT

Additional instructions: _____

Parent/Guardian Signature: _____

Date: _____

Staff Signature @ Check In: _____

Date: _____