Camper Name: _____

# Camp Fire Camp Toccoa

# Overnight Adventures

**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. 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.

| | | | | |
|---|---|---|---|---|
| Medication Name/Dosage: | Time Given: | BR EAKFAST | DINNER | BED |
| Medication Name/Dosage: | Time Given: | BR EAKFAST | DINNER | BED |
| Medication Name/Dosage: | Time Given: | BR EAKFAST | DINNER | BED |
| Medication Name/Dosage: | Time Given: | BR EAKFAST | DINNER | BED |
| Medication Name/Dosage: | Time Given: | BR EAKFAST | DINNER | BED |

Additional instructions: _____
_____
_____
_____
_____

Parent/Guardian Signature: _____ Date_____