

MEDICATION INFORMATION

Camper Name: _____

Camper Session: _____ Date(s): _____

**ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER, WELL MARKED,
AND GIVEN TO THE CAMP COORDINATOR UPON ARRIVAL.**

Name of Medication	Type of Medication	Dosage	Time to be given	Date given	Time given	Initials
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription					

Special Instructions:

PERMISSION FOR MEDICATION/MEDICAL TREATMENT ADMINISTRATION:

YES, I authorize Greenbush Camp Staff to administer medication and medical treatments as identified above.

Signature of Parent/Guardian

Date