

Medication Sheet

Camper Name _____ Session Date _____

1	Name of med		Time	Su	M	Tu	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									
2	Name of med		Time	Su	M	T	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									
3	Name of med		Time	Su	M	T	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									
4	Name of med		Time	Su	M	T	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									
5	Name of med		Time	Su	M	T	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									
6	Name of med		Time	Su	M	T	W	Th	Fr	Sa
	How many mg?									
	How many tablets									
	How many times a day?									

TURN OVER!

Medication Sheet

Camper Name _____ Session Date _____

7	Name of med									
	How many mg?									
	How many tablets									
	How many times a day?									
<hr/>										
8	Name of med									
	How many mg?									
	How many tablets									
	How many times a day?									
<hr/>										
9	Name of med									
	How many mg?									
	How many tablets									
	How many times a day?									
<hr/>										
10	Name of med									
	How many mg?									
	How many tablets									
	How many times a day?									

Primary Physician's Signature _____
Printed Name _____
Phone number: _____

Camper takes meds:	Tube Feeding Scheudle	
Whole	Bolus	
Crushed	Via Pump	
In juice	toal amount of feeding per day	
Apple sauce	Rate of feeding in on pump.	
Pudding		

DIABETIC

Glucometer readings
 ___ YES ___ NO
 How many times a day

Sliding Scale
 ___ YES ___ NO
****If on sliding scale
 you must provide a
 copy of the sliding
 scale signed by
 your physician**

CAMP MILLHOUSE HEALTH CARE STAFF ONLY	
Intl.	SIGNATURE

Originals only. No faxes or copies. Medications must be in original containers and must match med sheet. New sheet for each week will be needed. Please read and follow policies for medication and health forms.