

2020 Medication Sheet

Camper Name \_\_\_\_\_ Session Date \_\_\_\_\_

\*\*\* If your camper is diabetic or requires tube feedings or a CPAP, please call the office to request additional forms. If your camper does not take any medications, "No Meds" must be written on this form and the back must be signed by camper's physician.\*\*\*

EXAMPLE  
ONE MED PER LINE

Name of med	<i>Abilify</i>
How many mg/tab?	<i>5mg</i>
How many tablets/dose?	<i>1 Tablet</i>
How many times a day?	<i>2X/day</i>

Usual time: 8:00 am and 8:00 pm

1

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

2

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

3

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

4

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

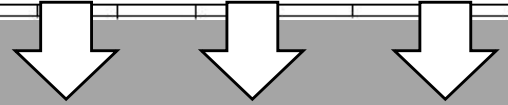
Usual time: \_\_\_\_\_

5

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

TIME	SUN	MON	TUE	WED	THU	FRI	SAT
This is where our Camp nurses keep track of meds given to the camper <u>WHILE THEY ARE AT CAMP</u> . Please do not write in this space. It is for <u>CAMP USE ONLY</u> .							



TIME	SUN	MON	TUE	WED	THU	FRI	SAT

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

Originals only. No stamps, white out, faxes or copies. Medication 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.

2020 Medication Sheet

Camper Name \_\_\_\_\_ Session Date \_\_\_\_\_

6

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

7

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

8

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

9

Name of med	
How many mg/tab?	
How many tablets/dose?	
How many times a day?	

Usual time: \_\_\_\_\_

TIME	SUN	MON	TUE	WED	THU	FRI	SAT

Primary Physician's Original Signature (no stamps): \_\_\_\_\_

Printed name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Camper takes meds:	
	Whole
	Crushed
	In Juice
	Applesauce
	Pudding

CAMP MILLHOUSE HEALTH CARE STAFF ONLY	
Intl.	SIGNATURE

\*\*\* If your camper is **DIABETIC** or requires **TUBE FEEDINGS** or a **CPAP**, please call the office to request additional forms. If your camper does not take any medications, **"No Meds"** must be written on this form and the back must be signed by camper's physician. Camp Office: 574-233-2202\*\*\*