Medication Administration Record for HS Camp 2025

I hereby grant permission to the administrative staff to administer this medication to my child as described.

Parent Printed Name: _____ Parent Signature: _____

Emergency Contact Number: _____ StudentAllergies & Reaction: _____

1. Please place medications in a Ziploc bag clearly labeled with the students full name written on the outside in permanent marker.
2. Medications must be in the original container (no pills in bags or daily dispensers).
3. Please send an inhaler if you child has asthma. Please send an Epi-pen if you child has a history of severe allergic reactions.
4. Please do not send Ibuprofen, Tylenol, Pepto Bismol, etc. These will be provided if needed.
5. Please provide us with only the number of days the individual will be at camp; do NOT provide extra.

EXAMPLE

MEDICATION	TIME TO BE TAKEN (Circle all that apply)	Dose: (tabs, tsp, puffs,etc)	Route: (oral, topical, inhalation)	Indication: (reason for taking medication)	Special Instructions: (ex: take with food, empty stomach)	Fri	Sat	Sun
Medication Name: Adderall **Check one:** RX (X) or OTC ( ) **Strength** (mg, mL, etc): 5mg	Breakfast Lunch Dinner Bedtime As Needed	1 tablet 1 tablet @ 2:00pm	oral	ADHD	take before breakfast and before a snack			
Medication Name: _____ **Check one:** RX ( ) or OTC ( ) **Strength** (mg, mL, etc): _____	Breakfast Lunch Dinner Bedtime As Needed							
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STAFF USE ONLY

STUDENTS *LAST* Name _____ **STUDENTS *FIRST* Name** _____ Date: _____