Medication Administration Record for High School Camp 2026

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

Parent Printed Name: _____

Parent Signature: _____ Date: _____

Emergency Contact Number:_____

Student Allergies & Reaction: _____

Cabin: _____
Notes:

STAFF ONLY

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.

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	Mon
EXAMPLE **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 _____

CAMPUS _____