



Youth Camp Medication Record

YEAR _____

Name: _____ Camper; Counselor/Leader; Other Staff; Church/Cabin: _____

Age/DOB: _____; Medication(s) Received (Date/Time): _____; Epi-Pen; Inhaler

Routine Medication(s)	Dosage	Purpose	Frequency (Circle One)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
				/	/	/	/	/	/
				List Time Medication Was Given					
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
			B L A D E						
PRN Medication(s)	Dosage	Reason for PRN Med(s)		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Notes/Special Instructions/Allergies:									
Approved OTC Medication(s):	<input type="checkbox"/> Cough Syrup; <input type="checkbox"/> Acetaminophen (Tylenol); <input type="checkbox"/> Ibuprofen (Advil/Motrin); <input type="checkbox"/> Benadryl – Allergic Reaction <input type="checkbox"/> (diphenhydramine); <input type="checkbox"/> Pepto-Bismol; <input type="checkbox"/> Topical(s) – Neosporin, Anti-Septic Spray; <input type="checkbox"/> Other: _____								

(B/L/A/D/E) B= Breakfast; L= Lunch; A= Afternoon; D= Dinner; E= Evening or Bedtime; PRN= As Needed; OTC= Over the Counter

Medication(s) Returned (Date/Time): _____ Nurse: _____ Date: _____