

REQUEST TO GIVE MEDICATIONS

Name: _____

Cabin: _____

Counselor: _____

() **Parent check here if camper needs meds on Sunday Evening.**

List below any acute or chronic medical or health problems the camper has, including the physician's diagnosis.

1. _____

2. _____

3. _____

Scheduled Medications:

I request that the designated Health Provider at Camp Mowana give my child the following medication and/or treatments on the schedule indicated.

Drug Name	Dosage	Schedule (Circle below)	Other
1. _____	_____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
2. _____	_____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
3. _____	_____	1x 2x 3x 4x 8am noon 5pm 9pm	_____
4. _____	_____	1x 2x 3x 4x 8am noon 5pm 9pm	_____

As Needed Only Medications:

Drug Name	Dosage	Reason	Schedule
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSTRUCTIONS: Place all medications in a paper or plastic bag marked with the name and cabin. Each container must have camper's name and the name of the medication before it can be accepted.

Signature: _____

Relationship to camper: _____

FOR NURSE USE ONLY

Meds/Treatment	Sched	SUN	MON	TUES	WED	THUR	FRI
1.	8 AM						
	12 PM						
	5 PM						
	9 PM						
2.	8 AM						
	12 PM						
	5 PM						
	9 PM						
3.	8 AM						
	12 PM						
	5 PM						
	9 PM						
4.	8 AM						
	12 PM						
	5 PM						
	9 PM						

PLEASE INITIAL IN THE APPROPRIATE DAY/TIME BOX FOR MED/TREATMENTS

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