



MEDICATION DISPENSED AT CAMP

DO NOT MAIL THIS FORM TO THE CITY OFFICE. PLEASE BRING THIS FORM TO LUGGAGE DROP OFF WITH YOUR CHILD'S MEDICATION

The following medication is to be given to my child while at camp:

Camper's Name: _____

Sex: M F

Program: Mini A Session 1 TSS/Hadracha Super Season
 Mini B Session 2 Agree Kennedy

Camper's Village: _____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Home Phone: _____ Cell Phone: _____

Do you want your child's medications to remain at camp during session break?
YES / NO

Food & Drug Allergies: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

* Daily medications are distributed at breakfast, lunch and dinner; unless specifically required at bedtime.

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

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Breakfast Lunch Dinner Bedtime* Other: _____

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Medication: _____

Dose: _____

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