Medication Administration Record 1

Camper Name: ______________________________

Birth Date: ______________________________

Parents/ Guardians: Please fill in medication information in blocks on left only. Please place medications In Original Containers into a sealable plastic bag that is clearly labeled with you campers name, date of birth, and allergies written in permanent marker on the out- side of the bag. Medications must be in original container with doctors directions if it is prescription (please no pills in bags or daily dispens- ers). Please send inhaler if your child has asthma. Please send Epi-Pen if your child has a history of severe allergic reactions.

Please fill out the medication, dosage, and frequency on the left.
Healthcare Provider: The date and time blocks to the right are for you to chart when medication was given.

(**Missing Dose Legend**: R= refused medication, S= skipped dose for medical reasons, N= no show)

Camp Dates:	**Dose**	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Medication: ___________	Breakfast							
____________________	Lunch							
Dosage: _____________	Dinner							
____________________	Bed							
Frequency: ___________								
____________________								
Comments:								

Camp Dates:	**Dose**	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Medication: ___________	Breakfast							
____________________	Lunch							
Dosage: _____________	Dinner							
____________________	Bed							
Frequency: ___________								
____________________								
Comments:								

Camp Dates:	**Dose**	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Medication: ___________	Breakfast							
____________________	Lunch							
Dosage: _____________	Dinner							
____________________	Bed							
Frequency: ___________								
____________________								
Comments:								

Camp Dates:	**Dose**	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Medication: _____________	Breakfast							
____________________	Lunch							
Dosage: _______________	Dinner							
____________________	Bed							
Frequency: _____________								
____________________								
Comments:								

Medication Administration Record 2

Camper Name: _____

Birth Date: _____

Allergies:

I give Cedarkirk Camp and Conference Center and its staff permission to administer medications as prescribed for my camper as name and listed on the MAR

Medication Check into camp by:

_____/ _____

Parent/ Guardian Signature & Date Health Officer Signature & Date

Medications Checked out by:

_____/ _____

Parent/ Guardian Signature & Date Health Officer Signature & Date

Only for Staff Members Dispensing Medications Below

Printed Name	**Signature**	**Initials**

Notes: