girl scouts of san gorgonio

MEDICATION RECORD

(Print legibly. Must be turned in at check-in first day of camp. Please print both pages)

☐ **Check here if child does not take medication**

Camper Name:	**Age:**	**Allergies:**
Physicians name:		**Physicians #**
Parent/Guardian signature:		

Medication Administration Key
B ~ 7:30-8:30 AM
L ~ 12:00-1:00 PM
D ~ 5:30-6:30 PM
Bed ~ 8:30-10:00 PM

Parent/Guardian/Physician complete this section	**For Camp Use Only**																			
	Date:				**Date:**				**Date:**				**Date:**				**Date:**			
	B	**L**	**D**	**Bed**	**B**	**L**	**D**	**Bed**	**B**	**L**	**D**	**Bed**	**B**	**L**	**D**	**Bed**	**B**	**L**	**D**	**Bed**
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				

girl scouts of san gorgonio

MEDICATION RECORD

(Print legibly. Must be turned in at check-in first day of camp)

Camper name:

Medication Administration Key
B ~ 7:30-8:30 AM
L ~ 1200-1:00 PM
D ~ 5:30-6:30 PM
Bed ~ 8:30-10:00 PM

Parent/Guardian/Physician complete this section

	For Camp Use Only																			
	Date:				Date:				Date:				Date:				Date:			
	B	L	D	Bed	B	L	D	Bed	B	L	D	Bed	B	L	D	Bed	B	L	D	Bed
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				
Medication: **Dose:** **Route:** **Special instructions/Side effects:**																				

Health Center Staff

Initials: _____ Print name: _____

Initials: _____ Print name: _____

Initials: _____ Print name: _____

Initials: _____ Print name: _____