Medication Administered Log

Week: _____

Cabin: _____

Counselor: _____
(Office only)

Camper Name: _____

Allergies: _____

Type of Medication	Dose	Frequency	
1.			
2.			
3.			
4.			
5.			
6.			

Special Instructions/Other Medical Concerns:

_____

_____

_____ _____ _____

Parent's Name (print clearly) Date Signature

Verification Medications Administered (completed by Camp Medical Staff)

Sunday	_____P.M.			
Monday	_____A.M.	_____Noon	_____Eve	_____ P.M.
Tuesday	_____A.M.	_____Noon	_____Eve	_____ P.M.
Wednesday	_____A.M.	_____Noon	_____Eve	_____ P.M.
Thursday	_____A.M.	_____Noon	_____Eve	_____ P.M.
Friday	_____A.M.	_____Noon	_____Eve	_____ P.M.
Saturday	_____A.M.			

Camp Medical Staff: Once the medication is administered, note above; print and sign name below:

_____ _____ _____

Staff Name (print clearly) Date Signature