

Calvin Camp Medication Form

Camper Name: _____

Dates Attending: _____

NOTES

CAMP MEDICAL STAFF SIGNATURE:

X

DOCTOR MUST LIST ALL MEDICATIONS BELOW, INCLUDING OVER THE COUNTER, VITAMINS, HERBS, HOMEOPATHICS, ETC

LIST Rx:	MON		TUES		WED		THUR		FRI		SAT														
Med:	Camp Personnel →	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9
Circle times to be given																									
To treat what?																									
Counter indications:																									

	MON		TUES		WED		THUR		FRI		SAT														
Med:	Camp Personnel →	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9
Circle times to be given																									
To treat what?																									
Counter indications:																									

	MON		TUES		WED		THUR		FRI		SAT														
Med:	Camp Personnel →	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9
Circle times to be given																									
To treat what?																									
Counter indications:																									

	MON		TUES		WED		THUR		FRI		SAT														
Med:	Camp Personnel →	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9	8	12	6	9
Circle times to be given																									
To treat what?																									
Counter indications:																									

If no Doctor's signature medication **WILL NOT** be given

PRESCRIBING DOCTOR'S SIGNATURE:

X

Date:

Phone:

Printed Name:

Address:

City:

State:

Zip: