DEPARTMENT OF LEISURE, FAMILY & RECREATION
Individual Camper Medication Record

CAMPER NAME:	**PHYSICIAN ORDERING MEDS/PH#:**
DRUG NAME/FORM/DOSAGE/TIME ORDERED:	**ASA OR ASA LIKE SUBSTITUTE REQUESTED BY PARENT, NO M.D. ORDER:**
STRENGTH/ROUTE/ADMIN. FROM (DATES) TO:	**PARENTS NAME / PHONE #:**
CAMPERS ALLERGIES TO FOOD/MEDICATIONS:	**REC'D FROM: DATE REC'D:**
SIDE EFFECTS OF MEDICATION TO BE OBSERVED:	**PHARMACY: DATE TO REORDER:**
REC'D AND CHECKED BY: QTY:	**RX #: RX DATE:**

Date (Mo/Day/Yr)	**Time Given**	**Dose Given**	**Legal Signature of Person Administering Medication**	**Comments**	**Amt. of Controlled Drug Remaining**