Medication Administration Record for Camp Edge 2017

I hereby grant permission to the administrative staff to administer this medication to my child as described.

Parents Printed Name:____ Parent Signature:___________________________________

Emergency Contact Number:___________________________ Student Allergies & Reaction:_________________________________

1. Please place medications in a Ziploc bag clearly labeled with the students full name written on the outside in permanent marker.
2. Medications must be in the original container (no pills in bags or daily dispensers).
3. Please send an inhaler if your child has asthma. Please send an Epi-pen if your child has a history of severe allergic reactions.
4. Please do not send Ibuprofen, Tylenol, Pepto Bismol, etc. These will be provided if needed.
5. Please provide us with only 3 days supply of medications.

MEDICATION	TIME TO BE TAKEN	**SPECIAL INSTRUCTIONS**	**FRIDAY**	**SATURDAY**	**SUNDAY**
Medication Name: ________________	**AM** **Noon** **PM** **Bedtime** **As Needed**				
Medication Name: ________________	**AM** **Noon** **PM** **Bedtime** **As Needed**				
Medication Name: ________________	**AM** **Noon** **PM** **Bedtime** **As Needed**				

STUDENTS LAST NAME:________________________ STUDENTS FIRST NAME:_________________________ DATE:_______________