

Medication Information Form

Camper's Last Name

Camper's First Name

Age Level Camp

Use this form to itemize each medication accompanying the camper to Lakeview.

Every prescription medication must be in its original container with the correct person's name of the label.

Over-the-counter and non-prescription medications must be in their original container(s).

/-----For Nurse Use-----/

Nurse✓	Drug Name / Strength	Dosage	Frequency	M	T	W	Th	F
				<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon <input type="checkbox"/> PM <input type="checkbox"/> Bedtime	<input type="checkbox"/> AM <input type="checkbox"/> Noon
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/-----For Nurse Use-----/