4-H Camp Medication & Prescription Form 2018

Alabama 4-H
Alabama Cooperative Extension System

Participant's Name: _____ Age: _____ Weight: _____

Camp: _____ County: _____ Cabin #: _____

Parent/Guardian Name(s): _____

Contact Phone #1: _____ Contact Phone #2: _____

INSTRUCTIONS: The following must be completed for each medication brought to camp that is to be taken by you or your child during 4-H camp. Please list medications in the order in which they are to be taken. This includes inhalers. Fill in the name and dosage (as listed on the container) for each medication, along with any special instructions (take with food, etc.). Please place a ✓ in the appropriate Day/Time slot under the parent column for when medicine should be administered. Or check mark As Needed next to dosage if appropriate. (HCP will initial as medication is given.) In the event that your directions differ from those on the original container, you must obtain a note from the prescribing physician confirming the directions that should be followed in administering medications to your child.

FOR CAMP USE ONLY:
DATE:

_____

HEALTH CARE PROVIDER:
(HCP's Initials)

_____

PLEASE SEND ONLY THE NUMBER OF PILLS YOU OR YOUR CHILD WILL NEED FOR THE CAMP SESSION–IN THE ORIGINAL CONTAINER(S).

PLEASE LIST any medications that should be kept with the participant at all times (i.e. EpiPen, inhaler):

_____

1. Name of Medication: _____ Dosage: _____

Special Instructions: _____

Give As Needed: ✓: ____	Breakfast		Lunch		Dinner		Bedtime		Other	
	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										

2. Name of Medication: _____ Dosage: _____

Special Instructions: _____

Give As Needed: ✓: ____	Breakfast		Lunch		Dinner		Bedtime		Other	
	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS

Participant's Name: _____

3. Name of Medication: _____ Dosage: _____

Special Instructions: _____

Give As Needed: ✓: ____	Breakfast		Lunch		Dinner		Bedtime		Other	
	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										

4. Name of Medication: _____ Dosage: _____

Special Instructions: _____

Give As Needed: ✓: ____	Breakfast		Lunch		Dinner		Bedtime		Other	
	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										

5. Name of Medication: _____ Dosage: _____

Special Instructions: _____

Give As Needed: ✓: ____	Breakfast		Lunch		Dinner		Bedtime		Other	
	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials	Parent ✓	HCP's Initials
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										