

Camper's Name _____ County/District _____

Please list all medications on both top and bottom portions of this form.

*****Return one half to the Extension Office before camp. Place the other half of this form in a zip bag with all medications.*****

All medications sent to camp must be in the original container.

Do not send over the counter medications that are available in the health center with your child.

Review a list of those items available at <http://www.midway.k-state.edu/4-h/events/4hcamp/index.html> – 4-H Camp Central

	Name of Medication	Dosage (Amount to be given)	Breakfast (AM)	Lunch (PM)	Dinner (PM)	Bedtime (PM)	PRN (as needed)	Reason taking Medication
1.								
2.								
3.								
4.								

Allergies: _____

Other Comments: _____

**No injection will be given except in extreme emergency, such as allergy to wasp or bee sting, etc.
** Regular doctor prescription daily injections will be given by nurse, as per orders on medication.

✂ _____

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