

Pioneer Trails 4-H Camp Group

Medication Form – (One form for each Prescription Medication)

County/District: _____ Campers Name: _____

Directions: Please place each medication in a separate resealable ziploc bag with this completed form. Medication **MUST** be in the original pharmacy label container/over the counter container. Medications **NOT** in an original container will **NOT** be given due to liability to the nursing staff. Agents are not responsible for prescription or over-the counter medications not delivered to agents/extension staff in an original container. **All prescription medications must be kept at the nurse's station except emergency medications, such as inhalers. If the medication is to be kept by the camper, please state health reason below.**

Prescription Name: _____ Over the Counter Name: _____

Dose: <i>Ex: 1tsp, 5mg</i>	Frequency/Time				Reason for taking medication
	M	L	D	B	

M=morning L=Lunch D=dinner B=bedtime

Allergies: _____

Adverse side effects noted: _____

Instructions: _____ Should be taken with food _____ Should not be taken with food _____ Other: _____

***No injections 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 the nurse as per orders on the medication.**

Parent/Guardian: _____ Date: _____

Pioneer Trails 4-H Camp Group

Medication Form – (One form for each Prescription Medication)

County/District: _____ Campers Name: _____

Directions: Please place each medication in a separate resealable ziploc bag with this completed form. Medication **MUST** be in the original pharmacy label container/over the counter container. Medications **NOT** in an original container will **NOT** be given due to liability to the nursing staff. Agents are not responsible for prescription or over-the counter medications not delivered to agents/extension staff in an original container. **All prescription medications must be kept at the nurse's station except emergency medications, such as inhalers. If the medication is to be kept by the camper, please state health reason below.**

Prescription Name: _____ Over the Counter Name: _____

Dose: <i>Ex: 1tsp, 5mg</i>	Frequency/Time				Reason for taking medication
	M	L	D	B	

M=morning L=Lunch D=dinner B=bedtime

Allergies: _____

Adverse side effects noted: _____

Instructions: _____ Should be taken with food _____ Should not be taken with food _____ Other: _____

***No injections 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 the nurse as per orders on the medication.**

Parent/Guardian: _____ Date: _____