

If possible, please give your child her/his medication prior to arrival and send only those that are necessary.

Medication will be checked-in with camp staff daily or weekly. All medication must be in original, pharmacy containers with the child's name printed on the prescription.

Child's Name _____ Date _____

Doctor's Name _____ Name of Medication _____

Possible reaction(s) that may occur (drowsiness, nausea, etc.) _____

Indications for use: _____

First Dosage Time and Amount _____

Second Dosage Time and Amount _____

Days that child will take medication: (please circle) MON (date: _____) TUES (date: _____)

WED (date: _____) THURS (date: _____) FRI (date: _____)

I UNDERSTAND THAT UNIVERSITY RECREATION SUMMER YOUTH CAMP STAFF MAY ADMINISTER THE ABOVE MEDICATION. I UNDERSTAND THAT THE CAMPS STAFF WILL SUPERVISE THE CHILD IN TAKING THEIR MEDICATIONS AS PER PARENT'S REQUEST AND DIRECTIONS LISTED ABOVE.

Signature Date

UREC Summer Youth Camps Staff, please record the time that the child took their medicine and the amount that they took below. **ONLY TRAINED UREC STAFF will administer medication.**

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	DATE:	DATE:	DATE:	DATE:	DATE:
TIME					
AMOUNT GIVEN					
STAFF INITIALS					