Easter Seals Camp Hemlocks
2008 Camper Medication Form

CAMPER'S NAME: _____ DOB: _____/_____/_____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

MEDICATION ARE DISPENSED AT THE FOLLOWING TIMES: B-Breakfast (8:00am), L-Lunch (12:00pm), D-Dinner (5:00pm), HS- Hour of Sleep (8:00pm) UNLESS OTHERWISE SPECIFIED:

NAME OF MEDICATION/ STRENGTH OF EACH PILL /ROUTE	DOSE/ # OF PILLS	TIME TO BE GIVEN	PRESCRIBING PHYSICIANS SIGNATURE	DATE

This form will be returned to you if it is not completed correctly and signed, Please check it carefully. If any changes are made to the campers medication once this form is completed you are responsible for providing the accurate updates or your camper will not be allowed to stay at camp.

1. This form must include **all** medication and treatments that are to be administered while at camp. **(Prescription and non-prescription).**
2. All medication must be in a labeled pharmacy bottle or bubble packed, with the accurate dosages, times, and instructions.
3. Each medication or treatment must be signed by the prescribing physician in the above section.
4. Any medication changes must be accompanied by a written physician's order.
5. All medication labels must match the orders written on this form.

IT IS THE RESPONSIBILITY OF ADULT CAMPER, PARENT/PROVIDER or GUARDIAN TO INSURE THAT ALL PRESCRIBING PHYSICIANS ARE AWARE OF ALL MEDICATION PRESCRIBED TO THIS PERSON.

I CERTIFY THAT I HAVE READ THIS INFORMATION AND WILL FOLLOW THE GUIDELINES. I UNDERSTAND THAT FAILURE TO FOLLOW THESE GUIDELINES MAY RESULT IN THE CAMPER NOT BEING ALLOWED TO STAY AT CAMP.

SIGNATURE OF AULT CAMPER, PARENT/PROVIDER or GUARDIAN: _____

NAME AND RELATIONSHIP TO CAMPER: _____ DATE: _____