Allergies:_____ Cabin:_____

(Camp Use Only) *(Camp Use Only)*

Daily Medication Sheet

For Regularly Scheduled Medications

Camper Name: Date: Session:

Daily Medication Name/Dosage	***Dates Given***														
After Breakfast (10:00 – 10:30 a.m.)															
After Lunch (2:00 – 2:30 p.m.)															
After Dinner (6:30 – 7:00 p.m.)															
After Chapel/Before Bed (10:00 – 10:30 p.m.)															

Staff: Please record *initials* in the appropriate box whenever a medication is given, and sign your name at the bottom.

☐ **Check this box if your child has NO REGULARLY SCHEDULED MEDICATIONS.**

I have completed the medication sheet and supplied Camp Sancta Maria with the medications that my child will need during his camping experience. I have noted the over the counter medications my child can be given. I have read and thoroughly understand the handbook. By signing this document, I give my total consent to Camp Sancta Maria and acknowledge that I am able to grant this consent to Camp Sancta Maria, and that I have read, understood, and agreed to the conditions of the Camp Sancta Maria handbook and the medication schedule for my child while at Camp Sancta Maria.

Print Name of Parent or Legal Guardian:_____

Signature of Parent or Legal Guardian:_____

Adjustment of medication approved:_____ Date:_____

Please complete BOTH sides of this form and bring to camp on check-in day.

Staff use only:

_____ _____ _____ _____ _____ _____

(Initials) *(Signature)* *(Initials)* *(Signature)* *(Initials)* *(Signature)*

Allergies:_____ Cabin:_____

(Camp Use Only) *(Camp Use Only)*

Over the Counter and As Needed Medications

CSM keeps the following over the counter medications in the infirmary. Your child will not need to bring any of these medications.

Please initial the shaded box next to each medication you approve.

These CANNOT be administered to your child WITHOUT YOUR CONSENT.

Camper Name: Date: Session:

Over the Counter Medications	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial
Motrin *(child or adult dose)*														
Tylenol *(child, junior, or adult dose)*														
Sudafed														
Tylenol Cold														
Benadryl														
Tussin DM														
Cough Drops														
Pepto Bismol/ Tums														
As Needed Medications (please list)	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial

Staff: Please record *date, time, dosage* and *initials* whenever a medication is given, and sign your name at the bottom.

Staff Comments:

Please complete BOTH sides of this form and bring to camp on check-in day.

Staff use only:

_____ _____ _____ _____ _____ _____

(Initials) *(Signature)* *(Initials)* *(Signature)* *(Initials)* *(Signature)*