CAMPER NAME: _____ **DATE:** _____ **SESSION:** _____

Allergies: _____ Cabin: _____

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

Daily Medication Sheet
For Regularly Scheduled Medications

PARENTS/GUARDIANS:

Your child's medications CANNOT be administered to your child WITHOUT YOUR CONSENT.

Please complete and sign BOTH sides of this form and bring it to Camp on check-in day. Thank you!

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

Staff: Please record date and initials whenever a medication is given, then initial and sign your name at the bottom of this page.

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.)														

I have completed the medication sheet and supplied Camp Sancta Maria with the medication(s) that my child will need during his/her camp session. I have noted the over the counter medications my child may be given. I have read and thoroughly understand the Parent 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 Parent 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: _____

Staff Use Only:

_____ _____ _____ _____ _____ _____

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

CAMPER NAME: _____ **DATE:** _____ **SESSION:** _____

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. You do not need to bring any of these OTC meds.

PARENTS/GUARDIANS:

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

These CANNOT be administered to your child WITHOUT YOUR CONSENT.

Please complete and sign BOTH sides of this form and bring it to Camp on check-in day. Thank you!

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

Over the Counter Medications	Parent Initials	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															
Imodium A-D															
Pepto Bismol/Tums															
As Needed OTC 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 Use Only:

Staff Comments:

_____ _____ _____ _____ _____ _____

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