Silver State Baptist Youth Camp

**Medication Form**

_____ _____ _____ ____

Camper's Last Name First Name Date of Birth Age

_____ _____ _____

Name of Church Camper is coming with to camp Church Location City State

Allergies: _____ **Please list ALL medications, vitamins, herbal supplements, and treatments camper will need while at camp. All medications must be in their original containers. Items not listed will not be given. Camp Dr. has standing orders for select OTC medications in case of emergency.**

| Medication Name | Dosage | Route | Frequency | Diagnosis |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

_____ _____

*Signature of Primary Care Provider (MD, DO, PA, NP) Date

_____ _____

*Signature of Parent or Guardian Date

**Below This Point Silver State Baptist Youth Camp Nurse Use Only**

| Monday | | Tuesday | | Wednesday | | Thursday | | Friday | |
|---|---|---|---|---|---|---|---|---|---|
| Time | Initial | Time | Initial | Time | Initial | Time | Initial | Time | Initial |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

_____ Medication Returned _____

Camp Nurse's Signature Date

*Must have signature of Care Provider as well as Parent or Guardian signature.