



MEDICATION INFORMATION FORM 2007

**This form must be submitted with your child's medications
at the luggage/ medical drop off**

Camper's Name: _____

Sex: M F

Program: Mini A Session 1 TSS Super Season
 Mini B Session 2 Agree Kennedy

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Home Phone: _____ Cell Phone: _____

Do you want your child's medications to remain at camp during session break?
YES / NO

Food & Drug Allergies: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

*** Daily medications are distributed at breakfast and dinner; unless specifically required at bedtime.**

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____

Medication: _____

Dose: _____

Amount (e.g. number of tablets, number of inhalations): _____

Time Given (circle all that apply):

Breakfast Lunch Dinner Bedtime* Other: _____

Instructions: _____