



2010 MEDICATION DISPENSED DURING CAMP
TEEN PROGRAMS

This form will be used by Tamarack Camps staff throughout the summer and is independent of the CampRx.com forms.

The following medication is to be given to my child while at camp:

Camper's Name: _____ Sex: M F

Program: Western 1 Alaska Agree 1
 Western 2 Kennedy Agree 2

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Home Phone: _____ Cell Phone: _____

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, lunch 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: _____

PLEASE MAIL THIS FORM TO THE CITY OFFICE BY JUNE 1, 2010