Pioneer Trails 4-H Camp Group

Medication Form – (*One form for each Prescription Medication)*

County/District:___________________________ Campers Name:_________________________________

Directions: Please place each medication in a separate ziploc bag with this completed form. Medication **MUST** be in the original pharmacy label container/over the counter container. Medications **NOT** in an original container will **NOT** be given due to liability to the nursing staff. Agents are not responsible for prescription or over-the counter medications not delivered to agents/extension staff in an original container. **All prescription medications must be kept at the nurses station except emergency medications such inhalers**. **If the medication is to be kept by the camper, please state health reason below.**

Prescription Name:_______________________ **Over the Counter Name:**_______________________

Dose: *Ex: 1tsp, 5mg*	Frequency/Time M	L	D	B	Reason for taking medication

M=morning L=Lunch D=dinner B=bedtime

Allergies:____

Adverse side effects noted:____

☐ **Should be taken with food** ☐ **Should not taken with food** ☐ **Other**

***No injections will be given except in extreme emergency such as allergy to wasp or bee sting, etc. Regular doctor prescription daily injections will be given by the nurse as per orders on the medication.**

Date:_______________________ Parent/Guardian:____

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Please print this form, single-sided on *bright yellow* paper. Revised: Feb 2015