

**ICSL MEDICATION ADMINISTRATION RECORD**

CAMP DATES: \_\_\_\_\_ through \_\_\_\_\_

**Parents/Guardians:** Please fill out Camper and Medication information in blocks on left only. Please place medications in a Zip-Lock bag, clearly labeled with your child's name and date of birth written in permanent marker. Medications must be in original container with doctors directions if it is a prescription (please no pills in bags). Please send inhaler if you child has asthma. Please send Epi-Pen if you child has a history of severe allergic reactions.

**Advisors:** The date and time blocks to the right are for you to chart when medication WAS NOT given.  
(R= refused medication, S=skipped dose for medical reasons, N= no show after reminders)

<u>Camper Information</u>		Start Date	SUN	MON	TUE	WED	THUR	FRI	SAT	SUN
Name: _____	_____									
Youth Group: _____	_____									
Medication: _____	_____									
Dosage: _____	_____									
Frequency: _____	_____									
<i>COMMENTS:</i>										
Medication: _____	_____									
Dosage: _____	_____									
Frequency: _____	_____									
<i>COMMENTS:</i>										

Youth Group Advisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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<i>COMMENTS:</i>										

Youth Group Advisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_