



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Medication Administration Form

Camper Name:	DOB:
Medication: Circle One: Prescription / Over the Counter	Reason for Medication:
Start Date:	Stop Date:
Times to be given:	Amount to be given:
Possible Side Effects:	Administration: (please circle one) <ul style="list-style-type: none">• Oral• Topical (please list area(s): _____)• Other (please list _____)
Above information consistent with label? (please circle one) Yes / No	Requires Refrigeration? (please circle one) Yes / No
Special Instructions:	
Parent Phone Number:	Physician Phone Number:

Physician Name

Signature

Date

Parent/Guardian Name

Signature

Date

Medication Log

Date	Time	Dosage	Reason Given	Side Effects?	Staff Initial

Names/Signatures/Initials of staff giving medication:
