

TRINITY SUMMER CAMP – PRESCRIPTION MEDICATION FORM
Physician's Order (to be completed by Physician)

Camper Name _____	Gender _____	Date of Order _____
Date of Birth _____	School _____	Grade _____
Reason for Medication _____		Order Expires (date) _____
Name of Medication _____		Date Medication Expires _____
Time to Give Medication _____	Route _____	Dose _____ Strength _____
Possible Side Effects _____		Frequency of Medication _____
Special Instructions: _____		Allergies _____

_____ Printed Physician's Name	_____ Physician's Signature	_____ Parent Signature
Camp Nurse Printed Name: _____		Signature _____
(Indicates Review of this form and Medication)		

Medication Administration Record (DATE / INITIALS)

JUNE _____

JULY _____

AUGUST

Name /positions	Initials	Name/position	Initials	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

CODES: X = Weekend H = Holiday A = Absent
N = None Available ED = Early Dismissal R = Refusal
F = Field Trip D/C= Discontinued O – Omitted

