

Winston Day Camp Prescription Medications Form

Individualized Medication orders for :

CAMPERS NAME: _____ **AGE:** _____ **SEX:** _____
.....

Name of medication: _____

Regimen: Daily: _____ PRN: _____

Date to be started: _____ Date to be discontinued : _____

How many times a day : _____ Times of the day: _____

Please Check : Pill: _____ Liquid: _____

REASON FOR MEDICATION: _____

Any Reactions:
.....

Additional orders (as deemed necessary by health care provider to be implemented by a R.N. ; i.e. peak flows, blood draws, lab work, wound dressing etc.)

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____
.....

I request that my child _____ receive the medication as prescribed below by our physician. The medication will be provided in the properly labeled original container. It will be administered by the Camp Nurse.

Parent's Signature

Date