Destination Science Medical Form

If your child needs medication at camp, please complete and return to camp Teacher.

Camp Location: _____

Camp Dates:_____

_____	_____	_____
Camper First Name	*Last Name*	*DOB (MM/DD/YYYY)*

_____	_____	_____	_____
Camper's Street Address	*City*	*State*	*Zip Code*

_____	_____	_____	_____
Parent/Guardian First Name	*Last Name*	*Relationship to Camper*	*Cell Phone Number*

_____	_____	_____	_____
Emergency Contact First Name	*Last Name*	*Relationship to Camper*	*Preferred Phone Number*

Medication *(parents please fill in appropriate box[es])*

Name of medication	Date started	Reason for taking it	Time(s) administered	Amount or dose given	How it is given
			◯ am ◯ pm		
			◯ am ◯ pm		

Allergies

Does your child have any know allergies? ◯ *YES* ◯ *NO*	*LIST ALLERGIES:*
If allergic, what are his/her symptoms?	
If allergic, what is the action plan for reaction?	
Does your child carry an EpiPen? ◯ *YES* ◯ *NO*	***If yes, please show staff the location of EpiPen & write location here:*

FOR CAMP STAFF ONLY *(please fill out each day medication is required to be administered)*

Day / Date	Name of medication	Time Given	Please print name (First/Last) of staff who administered medication	Staff Signature
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				