Pioneer Trails 4-H Camp Group

Medication Form – (One form for each Prescription Medication)

County/District: _____________________ Campers Name: _____________________

Directions: Please place each medication in a separate resealable ziploc bag with this completed form. Medication MUST be in the original pharmacy label container/over the counter container. Medications NOT in an original container will NOT be given due to liability to the nursing staff. Agents are not responsible for prescription or over-the-counter medications not delivered to agents/extension staff in an original container. All prescription medications must be kept at the nurse’s station except emergency medications, such as inhalers. If the medication is to be kept by the camper, please state health reason below.

Prescription Name: _____________________ Over the Counter Name: _____________________

<table>
<thead>
<tr>
<th>Dose: Ex: 1tsp, 5mg</th>
<th>Frequency/Time</th>
<th>Reason for taking medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>L</td>
</tr>
</tbody>
</table>

*M=morning L=Lunch D=dinner B=bedtime*

Allergies: _____________________

Adverse side effects noted: _____________________

Instructions: _____ Should be taken with food _____ Should not be taken with food _____ Other: _____________________

*No injections will be given except in extreme emergency, such as allergy to wasp or bee sting, etc. Regular doctor prescription daily injections will be given by the nurse as per orders on the medication.

Parent/Guardian: _____________________ Date: _____________________

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Extension offices - Please print this form, single-sided on *bright yellow* paper, if available.  Revised: Dec 2018