

Camper Medication Information

Camper Name _____ Week of Camp _____

Medication Name	Purpose	Dosage	Frequency/Time of Day
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Permission to give OTC medications? Yes No

What should we know about your camper to help us serve them best? _____

Please Note: Distribution of Medications begins at supper on Sunday.

Parent Printed Name _____ Phone Number _____

Parent Signature _____

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