Camp Medication Summary Form

County/Camping Group:

Camp Dates:

To be completed by the Unit Representative (or other person receiving meds from parent)				To be completed by Camp Medic(s)								To be completed at check-out	
Participant Name	**Medication Name**	**Medication Form Completed?**	**Received by:** (Unit Rep initials)	**Received at 4H Center by:** (Medic initials)	**Problems to be addressed**	**Dosage/Special Instructions**	**As Needed**	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**	**Checked out by:** (Medic initials)	**Notes**
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		
		☐ Yes ☐ No					☐	☐	☐	☐	☐		

Medication Container Rec'd by Camp Medic: ____________________

Medication Container Rec'd by Agent (end of week): ____________________