

AS-NEEDED and ONE-TIME MEDICATIONS LOG

CAMPER NAME / Medication (Name, Dose, Frequency)	ADMINISTERED BY Date, Time, Initials	REASON for administering dose	NOTES Effects, outcome, other
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

After camp session ends, please return all records of medications administered to the Northern Lights Regional Office within two weeks.
 I verify that all information within is correct and none withheld (Medical Coordinator signature): _____