

Camper:	<input type="checkbox"/> Kids <input type="checkbox"/> Junior <input type="checkbox"/> ChiRho <input type="checkbox"/> CYF	Dates: _____ to _____	Dr. Phone: _____
Medical Coord:	Allergies: _____		Parent Phone: _____

SCHEDULED MEDICATIONS

Medication (Name, Dose, Frequency): <i>Dose Administrator: Initial each dose. Mark omissions X with reason.</i>	Date → Time ↓	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1.							
2.							
3.							
4.							
5.							

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): _____