Next dose of medication is due _____ **HEALTH AND MEDICATION RECORD** PAGE _____ OF _____

Camper Name _____ Age _____ Sex _____ Assigned Group _____ R = Refused M = Missed

Session			**Session Dates** _ _ / _ _ / _ _ **to** _ _ / _ _ / _ _						
Medication	**Dose** (mg)	**Amount** (# of tabs or ml)	**Time**						
Beginning count ( )									
Beginning count ( )									
Beginning count ( )									
Beginning count ( )									
Beginning count ( )									
Beginning count ( )									

TREATMENT/Home Device	**APPLICATION**	**TIME**	**ADDITIONAL NOTES**

Please check if MEDS given by: Mouth ☐ G-tube ☐ w/applesauce or pudding ☐ with water ☐ crushed ☐

ALLERGIES _____ _____ _____ **SIGNATURE** _____

Next dose of medication is due _____ **HEALTH AND MEDICATION RECORD** PAGE _____ OF _____

TO BE COMPLETED BY MEDICAL STAFF ONLY		
INITIAL ASSESSMENT:	NO S/S ILLNESS/INJURY ☐	NO MEDICAL ASSISTANCE NEEDED ☐

DATE	**TIME**	**TREATMENT**	**DAY**	**DAY**	**DAY**	**DAY**	**DAY**	**DAY**

DATE	**TIME**	**REASON FOR VISIT/ASSESSMENT**	**TREATMENT**	**PROVIDER'S INITIALS**

NURSE'S NAME	SIGNATURE w/Credential	INITIALS

ALLERGIES _____ _____ _____ **SIGNATURE** _____