

SOCAL CAMP MEDICAL/MEDICATION ADMINISTER FORM

This form must be completed by the Parent/Guardian of ALL campers, with or without medication. If camper is 18, they may fill out the form. **The only intended recipient is the camp's nursing office, please do not give this form to any other 3rd party.**

Name of Camper/worker _____
Birth Date: ____/____/____
Age: _____ Church/Group: _____

Asthma: YES | NO
Lactose Intolerant: YES | NO
Heart Disease: YES | NO
Convulsions: YES | NO
Diabetes: YES | NO
Are all shots current and up to date for Camper? YES | NO

Allergies (food, medications, animals, insects, etc.): _____

Activity Restrictions: _____

MEDICATION MUST BE SENT IN THE ORIGINAL PHARMACY CONTAINER

Please list medications being sent and written Instructions of how and when medication is to be administered:

