

Camp Horseshoe Medication Records

Dates of Camp: _____ to _____

Name: _____ Troop _____ Campsite _____

Date of Birth _____ Height _____ Weight _____

Allergies _____

Name of Parent/Guardian _____ Relationship to patient _____

Phone Number: Home _____ Work _____ Cell _____

Please fill out one section for each medication to be administered at Camp. **This form should be completed for anyone who will be staying overnight at camp. This includes scouts and adults who need to take medication while at Camp Horseshoe.**

All medications must be in the original container with the original label prepared by the pharmacy or physician which provides all of the customary information such as the patient's name clearly marked, drug name, dosage and instructions. All non-prescription medication must be marked with the patient's name and any instructions.) **WE ASK THAT THIS FOFM BE COMPLETED BY THE PARENT OR GUARDIAN AND TURNED IN TO THE HEALTH LODGE AT THE START OF THE SCOUT'S CAMPER WEEK.**

All medications (except Epic pens and inhalers) must be turned in to the Health Lodge at the start of the patient's stay in camp.

EPIPENS AND RESCUE INHALERS need to be carried by the scout at all times while at camp, in accordance with the prescription or instructions from the patient's physician. They do not need to be handed into the Health Lodge.

NOTE TO PARENTS/GUARDIANS: If your child fails to appear at the Health Lodge at the prescribed time to receive a medication dose, the troop's adult leaders will be notified with a request that the scout should be sent to the Health Lodge. All medications administered to the scout by the Health Lodge will be noted on this form. At the end of the scout's camper week, a copy of this form can be sent to the parent or guardian if an e-mail address is provided, so that parents or guardians will know when the child received medication. If you have any question at any time regarding your child, you may e-mail the Health Lodge at hshealthlodge@cccbsa.org. This e-mail is confidential and is only viewed by the camp nurse and doctor.

Name of Scout _____ **Troop** _____

Medication name/ Strength: _____

Dosage (how many and when?): _____

Quantity sent to camp: _____

Relevant side effects (reactions to food, sun sensitivity, nausea, drowsiness, etc.): _____

FOR HEALTH LODGE STAFF ONLY

Time:	Breakfast	Lunch	Dinner	Hour of Sleep
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

This information is confidential and is provided to the Camp Health Officer or designee for the express purpose of helping to ensure a healthy and safe week at Camp Horseshoe. This form may be shared with medical personnel should the necessity arise and will be part of your child's medical records.

Signature of Parent/Guardian _____ Date: _____

Signature of Health Officer: _____ Date: _____

Name of Scout _____ **Troop** _____

Medication name/ Strength: _____

Dosage (how many and when?): _____

Quantity sent to camp: _____

Relevant side effects (reactions to food, sun sensitivity, nausea, drowsiness, etc.): _____

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Signature of Parent/Guardian _____ Date: _____

Signature of Health Officer: _____ Date: _____