

CAMP FIRE MEDICATION ADMINISTRATION RECORD

Name: _____ Group: _____

Parents/Guardians:

- Please fill in medication information in blocks on left only.
- Please place medications **IN ORIGINAL CONTAINERS** into a sealable plastic bag that is clearly labeled with your child’s name and date of birth written in permanent marker on the outside of the bag.
- Medications must be in the original container with the doctor’s directions if it is a prescription (please no pills in bags or daily dispensers).

Administrator: Please chart when medication **WAS** given. Please put a checkmark for each dose administered.

(Missing Dose Legend: R= *refused medication*, S=*skipped dose for medical reasons*, N=*no show*)

Camp Dates:	Dose Time	Mon	Tues	Wed	Thurs	Fri
Medication: _____	AM					
Dosage: _____	PM					
Frequency: _____						
Medication: _____	AM					
Dosage: _____	PM					
Frequency: _____						
Medication: _____	AM					
Dosage: _____	PM					
Frequency: _____						

Reason for Meds: _____

I HEREBY AUTHORIZE the designated representatives of Camp Fire to administer the medication described above. In consideration of the administration of this medication in accordance with the directions of my child’s doctor, I hereby release Camp Fire and its employees from any and all liability for damages resulting from the administration of this medication to my child. I further agree to hold harmless and indemnify Camp Fire and its employees from any costs or expenses associated with any claim brought against them for actions taken pursuant to this Authorization to administer medication and such indemnification to include attorney fees, costs of litigation or claim or any damages or out of pocket costs occasioned by Camp Fire, or employees.

Parent/Guardian Signature: _____ Date: _____