Camper Name: _____ 2019
Last First Middle

Please fill this section out accurately and completely. **If changes to medical condition and/or medication occur and are different from what you listed on this form, contact the camp office as soon as possible, prior to camp.** List all medications and treatments prescribed to the camper including: lotions, creams, inhalers, liquids, allergy medications, cold medications, injections, and temporarily prescribed medication, including all over the counter medications, vitamin/mineral supplements, nutritional supplements, herbs, homeopathic remedies, other treatments, etc. that camper is currently taking. Administration advice is greatly appreciated. If camper will not be taking medications, etc. at camp, but takes them routinely, at other times, please list what is taken and in Comments section, please mention that they won't be taken at camp.

Medication Correspondence Contact Name: _____ Relationship to Camper: _____

E-mail: _____ Primary Phone: (____) _____- _____ ☐home ☐mobile ☐work ☐ text OK?
Secondary Phone: (____) _____- _____ ☐home ☐mobile ☐work ☐ text OK?

Correspondence Contact Address: _____-_____
City State Zip Code +4

☐ **<- Please check box if camper has a DNR (Do Not Resuscitate) order in place. Please provide a copy for camp.**

Medications will be dispensed at B-Breakfast, L-Lunch, D-Dinner, HS-Hour of Sleep unless otherwise specified below under "Comments or Special Instructions" section.

·If a medication is used for sleep purposes or will make camper very drowsy at bedtime, please mark it as HS as opposed to a specific time, as bedtime at camp is not necessarily your camper's normal bedtime.

·If medication needs to be dispensed at a specific time (for pain, blood pressure, blood sugar, or seizures, for instance), please make sure to list specific time/s medication is to be administered as opposed to using approximations (B, L, D, HS); make sure to use the comment section.

Each item listed must include accurate name, strength, dosage, times, and comments/instructions as necessary. The following page will have a continuation of this form, for your convenience; if you need more lines/space, please go online to print the form or make a copy of the pages.

☐ **N/A <- Please check box if camper takes no medication, supplements, OTC remedies, etc.**

Name of Medication Strength of Each Individual Pill and Route	Dosage At Each Time	Times use B, L, D, HS if possible	Comments or Special Instructions crushed, with food or how medication is given at home side effects, history of refusal or hiding medication
Ibuprofen - 200 mg, oral ***Example*** *Pill = Ibuprofen *Strength = 200 mg *Route = oral	200 mg	B	Take with food and plenty of water.
	200 mg	L	Take 30 minutes before meal; take on empty stomach.
	100 mg	@4:30 PM	Split 200 mg tablet in half, crush, mix with pudding.
	100 mg	HS	Split 200 mg tablet in half & take with water, might refuse.

Please return completed Paperwork to: Make Promises Happen, #1 Twin Cedar Lane, Guthrie, OK 73044-7041

Camper Name: ______________________________
Last First Middle

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Name of Medication Strength of Each Individual Pill and Route	**Dosage** **At Each Time**	**Times** use B, L, D, HS if possible	**Comments or Special Instructions** crushed, with food or how medication is given at home side effects, history of refusal or hiding medication

Please update camp whenever there is a change in medication and medical information.

Please return completed Paperwork to: Make Promises Happen, #1 Twin Cedar Lane, Guthrie, OK 73044-7041