CAMP ABLE INDIVIDUAL MEDICAL FORM

Complete this form only if the services of the Camp Able Nurse will be required to administer medications or medical treatments.

Camper's Name: _____

Physician Orders

Medication Name | Dosage | Route of Administer | Schedule At Camp

Nurse Notes

Day M T W TH F

Date _____

1. _____ Time & Initials _____
2. _____ Time & Initials _____
3. _____ Time & Initials _____

Medical Treatment Schedule at Camp
(catheterization, tube feeding, etc.)

1. _____ Time & Initials _____
2. _____ Time & Initials _____
3. _____ Time & Initials _____

PARENT/GUARDIAN, PLEASE SEND ALL EQUIPMENT NEEDED FOR TREATMENTS. SEND EACH MEDICATION IN A SEPARATE CONTAINER, LABLED WITH THE CAMPER'S NAME, MEDICATION, NAME, DOSAGE, AND SCHEDULE FOR ADMINISTAREING.

Health Care Provider's Signature _____

Camp Able Nurse's Signature _____

Notes: