Medication Administration Form

Experiential Leadership Institute

Week # ____________ Camper Name ______________________________________ Location ___________ Site Director Names _______________________

Parents Complete		For Use By Grow Day Camp Site Directors																											
Please list only the medications to be taken at camp	Date																												
	Day of the Week	SUNDAY				MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY			
	Time	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS	B	L	D	HS
Name of Medication:	**Dosage Amount:**																												
Circle all times to be administered: Breakfast - Lunch - Dinner - Bedtime																													
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Medication Administration Signature/Initial: ___________________________/_________ ___________________________/_________ ___________________________/_________ ___________________________/_________

Medication Administration Release

- I attest that the information given in the above “Camper Medication Record” is accurate and truthful.

- I understand that all medications for my ELI Participant will be administered by an Grow Site Director and that a nurse will serve in a consultative or emergency role only.

Parent/Legal Guardian Signature ____ Date _________/_________/___________

Parent/Legal Printed Name ____ Phone ____________________________

Camper Name ______________________________