

# Medication Administration Form



Experiential Leadership Institute

Week # \_\_\_\_\_

ELI Participant Name \_\_\_\_\_

Location \_\_\_\_\_

Site Director Names \_\_\_\_\_

Parents Complete		For Use By Grow Day Camps Site Directors																																		
Please list only the medications to be taken at camp	Date	SUNDAY							MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY							
	Day of the Week	B	L	D	H	S	B	L	D	H	S	B	L	D	H	S	B	L	D	H	S	B	L	D	H	S	B	L	D	H	S	B	L	D	H	S
	Time																																			
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 a 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 \_\_\_\_\_

**Participant Name**

\_\_\_\_\_