Silver State Baptist Youth Camp

Medication Form

________________ ________________ __________ ____

Camper's Last Name   First Name   Date of Birth   Age

Hillcrest Baptist Church   El Paso   TX

Name of Church Camper is coming with to camp   Church Location City   State

Allergies: ____________________ **Please list ALL medications, vitamins, herbal supplements, and treatments camper will need while at camp. All medications must be in their original containers. Items not listed will not be given. Camp Dr. has standing orders for select OTC medications in case of emergency.**

Medication Name	Dosage	Route	Frequency	Diagnosis

________________________ __________

*Signature of Primary Care Provider (MD, DO, PA, NP)   Date

________________________ __________

*Signature of Parent or Guardian   Date

Below This Point Silver State Baptist Youth Camp Nurse Use Only

Monday		Tuesday		Wednesday		Thursday		Friday	
Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial

________________________ Medication Returned __________

Camp Nurse's Signature   Date

*Must have signature of Care Provider as well as Parent or Guardian signature.