Medication Check-in Sheet

Parent Name: _____

Parent Phone Number: _____

Leader/Grade: _____

Cabin: _____

Student Name: _____

Age: _____

Allergies: _____

Student has scheduled medication for (circle):

Breakfast Lunch Dinner Bedtime

Student may receive OTC medication from nurse:

Yes No circle if need red dye free

MEDICATION	DOSAGE	CIRCLE:	ADD'L INSTRUCTIONS
		Breakfast Lunch	
		Dinner Bedtime	
EMERGENCY MEDICATION	**DOSAGE**	**WHO HAS MEDICATION**	**ADD'L INSTRUCTIONS**
