## MSYC Camper Medication Administration Record

Camper's Full Name:				Year Week #:				
Date of Birth:	Allergies:	Male / Female Cabin #:						
	1	<del></del>	Administration Times					
Medication Name / Dosage	Administration Instructions	Days of the Week	В	L	D	HS	Other	
Wedication Name / Bosage	Administration histractions	Sunday	+	L	Ъ	115	Other	
		Monday						
		Tuesday	1					
		Wednesday						
		Thursday						
		Friday	7					
		Sunday						
		Monday						
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		Sunday	,					
		Monday	7					
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		Thursday						
		Friday						
		Sunday						
		Monday						
		Tuesday	7					
		Wednesday	/					
		Thursday	7					
		Friday	7					
		Sunday						
		Monday						
		Tuesday						
		Wednesday						
		Thursday						
		Friday						
	1	111445	1				I	
Staff Assisting With Medic	cation Administration	Authorization						
Print Name	Initials	I,	(name of parent/guardian),					
		give my consent to th	my consent to the Health Care Staff at MSYC to administer the above					
		medications to	(name of camper)					
		during their time at M						
		Signature:						
		Relationship:		Date:				