MSYC Camper Medication Administration Record

Camper's Full Name: ____________________________________ **Year ___________ Week #: __________________**

Date of Birth: _____________ **Allergies: ___________________________** **Male / Female** **Cabin #: ________**

Medication Name / Dosage	Administration Instructions	Days of the Week	Administration Times				
			B	L	D	HS	Other
		Sunday					
		Monday					
		Tuesday					
		Wednesday					
		Thursday					
		Friday					
		Sunday					
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		Tuesday					
		Wednesday					
		Thursday					
		Friday					
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		Thursday					
		Friday					

Staff Assisting With Medication Administration	
Print Name	Initials

Authorization

I, ______________________________ (name of parent/guardian),

give my consent to the Health Care Staff at MSYC to administer the above

medications to _______________________________ (name of camper)

during their time at Mid-South Youth Camp.

Signature: ______________________________________

Relationship: _________________ Date: ___________________