Medication Distribution Record Form

Camper Name: ______________________________

Camp Session: ______________________________

Medication Allergies: ____

Please list each medication and dosage below and place a check mark in the box next to the distribution time.
If more space is needed, please use a second sheet.

			This section is for use by our Health Care Professional Only						
Medication *(List name, dose, & frequency)*	**Dosage Time**		**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
		Breakfast							
		Mid-Morning Coffee Break							
		Lunch							
		Mid-Afternoon Coffee Break							
		Dinner							
		Bed Time							
Medication *(List name, dose, & frequency)*	**Dosage Time**		**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
		Breakfast							
		Mid-Morning Coffee Break							
		Lunch							
		Mid-Afternoon Coffee Break							
		Dinner							
		Bed Time							
Medication *(List name, dose, & frequency)*	**Dosage Time**		**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
		Breakfast							
		Mid-Morning Coffee Break							
		Lunch							
		Mid-Afternoon Coffee Break							
		Dinner							
		Bed Time							
			RHR Health Care Provider Name:						

I do hereby grant permission for Rawhide Ranch to distribute the above listed medications as directed on this form:

Parent Signature: ______________________________ Date: ____________________