

MEDICATION DISTRIBUTION FORM

Child: _____ Church: _____

Cabin: _____ Allergies: _____

I hereby request that the volunteer nurse administer the following medication to my child at _____:
I understand that the drug to be administered must have been prescribed for the child
to whom it is to be administered and must further be in the container in which it was dispensed.

All medications for my child are in a zip locked bag with child's name.
All medication is in original container labeled with name and dosage.
If liquid medication ~ I have also enclosed a medication measuring spoon.

Parent/Guardian Signature Date

NAME OF MEDICATION

DOSAGE

FREQUENCY

I.e. times, meals, bedtime, as needed, etc

- | | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |

Please fill out the following information in case we have questions regarding your child's medication

Home Phone No. _____ Cell Phone No. _____

Person to contact if parents cannot be reached:

Name _____

Relationship to Child _____

Phone No. _____