MEDICATION ORDER FORM AND ADMINISTRATION RECORD

Colorado State Law requires a written order from an authorized prescriber for the Camp Medical Professional to administer medication. This includes all over the counter meds, supplements, herbs, and topical medications.

☐ Check here to indicate that this camper **does not take ANY medication**. **Form must still be signed.**

Name of Camper:_____ **Columns to be completed by Camp Medical Professional**

Please clearly print the medication name, dose, route, reason for use and circle times to be given for EACH medication.		Sun	Mon	Tue	Wed	Thu	Fri
	Date						
	Times to be given (circle)						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast (8 AM)						
	Lunch (12 PM)						
	Dinner (5:30 PM)						
	Bedtime (8:30 PM)						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						

Physician's Signature (REQUIRED) _____ **Date** _____

Physician's Name (Please Print) _____ Phone_____

Address, City, State, Zip _____

Signature of staff administering medication: _____ Initials: _____ Date:_____

MEDICATION ORDER FORM AND ADMINISTRATION RECORD (cont.)

Name of Camper:_____

Please clearly print the medication name, dose, route, reason for use and circle times to be given.		Sun	Mon	Tue	Wed	Thu	Fri
	Date						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast (8 AM)						
	Lunch (12 PM)						
	Dinner (5:30 PM)						
	Bedtime (8:30 PM)						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						
Medication: **Dose:** **Route:** **Reason for use:**	Breakfast						
	Lunch						
	Dinner						
	Bedtime						
	PRN						
	Other _____						

Physician's Signature (REQUIRED) _____ **Date** _____
Physician's Name (Please Print) _____

Signature of staff administering medication: _____ Initials: _____ Date:_____