



---

**MEDICATION REQUEST FORM**

**To be completed and signed by physician:**

Name of Camper \_\_\_\_\_

Diagnosis \_\_\_\_\_

Name of medication \_\_\_\_\_

Dosage: \_\_\_\_\_

Amount: \_\_\_\_\_

Time: \_\_\_\_\_

Side effects to report: \_\_\_\_\_

Side effects to expect: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician (with stamp)

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_