IF ATTENDING A SUMMER RESIDENT CAMP PROGRAM, YOU DO NOT NEED TO FILL OUT THIS FORM.
ON CAMPDOC.COM YOU WILL ENTER YOUR MEDICATIONS, PRINT THE MEDICATION AUTHORIZATION FORM, AND IT WITH YOUR MEDICATIONS TO CAMP.
THIS FORM WILL BE USED FOR TROOP CAMPING, MINICAMPS, TRAVEL, PROGRAM EVENTS, ETC. QUESTIONS ABOUT THIS FORM? CONTACT CAMP@GSUTAH.ORG

girl scouts of utah

MEDICATION LOG

IF THERE IS NO MEDICATION COMING WITH YOU TO THE PROGRAM, YOU DO NOT NEED TO BRING THIS FORM.

Name _____ ❑ Camp Cloud Rim ❑ Trefoil Ranch ❑ Minicamp/Event ❑ Other
Last First

Program date _____ Program name _____

Parents/guardians please note:

- Complete non-shaded areas for each medication to accompany your daughter or yourself.
- **All medication (prescription, over-the-counter, herbal, etc.) needs to be in its original container. No exceptions!!**
- **All prescription medication must be prescribed for the individual taking the medication. No exceptions!!**
- **Adults and minors attending programs must turn in medications.**
- For medications that are marked "as needed", your child is responsible to seek out the first aider to request her medication.
  - The staff/volunteers will not seek out your daughter to assist with "as needed" medication.
  - At day events, overnighters, and minicamps, the staff/volunteers cannot provide over-the-counter medications without first obtaining parental consent over the phone (unless a Health History & Consent form was turned in as well).
- Inhalers and Epi Pens stay with the person or, if a minor, they can stay with the minor or with an adult first aider attending the program depending on your preference (see separate Epi Pen Authorization form).
- When filling out this form:
  - List each medication in a new box.
  - List exact dosage (i.e. milligrams or teaspoons).
  - Mark the time of day the medication should be taken.
  - List any special comments in comment box.

Please note

I hereby give permission for staff/volunteers to assist my child to take the following medications according to the directions on the label and the information provided below. Staff/volunteers assists campers with their medications after the meal and at bedtime.

Please sign Parent/guardian signature _____ Date _____

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
Claritin	10 mg. (1 pill)	❑ Breakfast								Must take with food.
		❑ Lunch								
		❑ Dinner								
Example		☒ Bedtime	For Office Use Only							
		❑ Other								
		❑ As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other								
		❑ As needed								

PARTICIPANT NAME: ____

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other:								
		❑ As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other:								
		❑ As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other:								
		❑ As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other:								
		❑ As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		❑ Breakfast								
		❑ Lunch								
		❑ Dinner								
		❑ Bedtime								
		❑ Other:								
		❑ As needed								