CAMP BERACHAH HEALTH SERVICES
MEDICATION INTAKE FORM

CAMPER: **GENDER:**	**PROGRAM:**	**CABIN/COUNSELOR:**
NOTES:		

Rx 1: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____	Rx 2: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____
Rx 3: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____	Rx 4: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____
Rx 5: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____	Rx 6: _____ prn 0800 1200 1730 2100 Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____ Time: _____ Dose:_____

All medications, both prescription and over-the-counter, must be accompanied by this form. All medications must be in the ORIGINAL CONTAINER and prescription medications must be in the labeled prescription bottle. Medications stored in envelopes, baggies, etc., WILL NOT BE ACCEPTED! If changes are made in your camper's medication regimen once this form is completed, you are responsible for providing accurate and prompt updates. All medications and treatments (including lotions, inhalers, allergy/cold medications, etc.) must be included on this form. Each prescribed medication or treatment must be signed by the prescribing physician; labels on medication containers must match this medication information form. It is the parent/provider or guardian's responsibility to insure that all prescribing physicians are aware of all medications prescribed to this camper and that no contraindications or interactions exist. Medications must be picked up at the end of the week, or will be disposed of after three (3) weeks from the last day of camp. By signing below I give permission for Camp Berachah staff to administer the prescribed medicaitons listed above to my child while attending Camp Berachah.

Parent/Guardian Signature: _____ Date: _____

Number we can contact you:_____ **Cell Number:**_____

CAMP BERACHAH HEALTH SERVICES
MEDICATION DISPENSE FORM

Rx 1: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
S	Time:	Dose:	

Rx 2: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
S	Time:	Dose:	

Rx 3: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
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W	Time:	Dose:	
W	Time:	Dose:	
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W	Time:	Dose:	
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Rx 4: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
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T	Time:	Dose:	
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W	Time:	Dose:	
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TH	Time:	Dose:	
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F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
S	Time:	Dose:	

Rx 5: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
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M	Time:	Dose:	
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T	Time:	Dose:	
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TH	Time:	Dose:	
TH	Time:	Dose:	
TH	Time:	Dose:	
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F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
S	Time:	Dose:	

Rx 6: _____

			INT.
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
M	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
T	Time:	Dose:	
W	Time:	Dose:	
W	Time:	Dose:	
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TH	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
F	Time:	Dose:	
S	Time:	Dose:	