

Medication Form

Westminster Woods Camp * 18487 Barber Rd * Fall River *
KS * 67047

If your child does NOT take medications, you do not have to fill out this form!

Any and all medications that your student will be taking must be accurately described on this form.

Name of Camper: _____ Known allergies: _____

Guardian Name: _____ Cell Phone: _____

Medication(s) to be taken during event: All Medications must be in original container

1) Name: _____ **Dosage:** _____

Circle time to be taken with: Breakfast Lunch Dinner Evening Snack Bedtime As Needed

2) Name: _____ **Dosage:** _____

Circle time to be taken with: Breakfast Lunch Dinner Evening Snack Bedtime As Needed

3) Name: _____ **Dosage:** _____

Circle time to be taken with: Breakfast Lunch Dinner Evening Snack Bedtime As Needed

4) Name: _____ **Dosage:** _____

Circle time to be taken with: Breakfast Lunch Dinner Evening Snack Bedtime As Needed

I hereby give permission for this medical information to be shared on a need to know basis.

Parent or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Place all medications listed in a Ziploc bag with the student's name printed on the front. Please include this form in the Ziploc bag.

**Please bring this form
with your camper when
you arrive at camp.
DO NOT SEND IN
ADVANCE**