

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!

Send this form with the camper. Do not send in advance. Please send medication in original bottle.

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

Name of Camper: _____ Known allergies: _____

Parent/Guardian Name: _____ Cell Phone: _____

Medication(s) to be taken during event:

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 original prescription bottle) in a Ziploc bag with the student's name printed on the front. Please include this form in Ziploc bag.