Please complete and bring to camp on September 4

Name _____ Allergies _____

CAMP YOUCAN MEDICATION SCHEDULE					
DRUG NAME	**STRENGTH**	**TIME OF DAY/DOSE**			
		9-10AM	**12-1PM**	**5-6PM**	

Parent signature at **time of check in**:_____

All seizure meds will be returned upon official check out of Camp YouCan. Until that time all medication will be distributed by medical staff at Camp YouCan.

EMERGENCY INFORMATION

_____

CAMPERS NAME (LAST) (FIRST) AGE WEIGHT

_____

ADDRESS (STREET) CITY STATE ZIP HOME PHONE

_____

PARENT/GUARDIAN EVENING/DAY PHONE

_____

EMERGENCY CONTACT PERSON PHONE

_____

CHILD'S PHYSICIAN PHONE

ALLERGIES_____

RESCUE MEDICATION (I.E. DIASTAT, ATIVAN): _____ DOSE_____

FREQUENCY OF USE: _____ LAST USED: _____