

FUEL MINISTRY CAMP MEDICATION ADMINISTRATION RECORD

Rider's Name _____ Allergies _____

MEDICATION: _____ DOSE: _____

Time to be Given	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials
Breakfast					
Lunch					
Supper					
Bedtime					
Other					

MEDICATION: _____ DOSE: _____

Time to be Given	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials	Date/Time Initials
Breakfast					
Lunch					
Supper					
Bedtime					
Other					

Additional Instructions: _____

I, _____, HEREBY GIVE PERMISSION FOR THE VOLUNTEER STAFF AT FUEL MINISTRY CAMP TO ADMINISTER THESE MEDICATIONS TO MY CHILD, _____, ACCORDING TO LABEL OR PACKAGE DIRECTIONS.

PARENT/GUARDIAN SIGNATURE _____ DATE ____/____/____ PHONE NUMBER _____

Initials _____ Name _____ Signature _____

Initials _____ Name _____ Signature _____