Team _____

FUEL CAMP MEDICATION ADMINISTRATION RECORD

(Prescription Medications)

Rider's Name _____ **Age** _____ **Weight** _____

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** _____/____/_____

PARENT / GUARDIAN NAME (Print) _____

PHONE NUMBER _____

Initials _____ Name _____ Signature _____

Initials _____ Name _____ Signature _____