ADDENDUM TO THE 4-H CAMP YOUTH HEALTH FORM
Prescription and over the counter Medication Form

Year: _____
County: _____

NAME OF 4-H MEMBER _____ Date of Birth _____ **GENDER**_____
First Middle Last

PRESCRIPTION MEDICATIONS GUIDELINES

- **All medications must be in ORIGINAL CONTAINERS with the original pharmacy printed labels or the original over the counter container with legible instruction label.**
- 4-H staff are **only** permitted to give medications according to **dosage on ORIGINAL CONTAINERS**. If current dosage is different than what is indicated on the label, **a doctor's note must be included**.
- ALL medications will be turned in to the **CAMP NURSE** at **check-in.** 4-H members **are not permitted to keep** medications with them in the cabins. Include only the number of pills needed for **the** duration of program.

Please **complete the information** below for each medication that the camper will need to take during the program. For each medication, place a check mark in the "**To Be Taken**" column (mark all meals/bedtime as applicable) for each day that camper should take the medication.

1. MEDICATION: Dosage:

Condition treated:_____ Frequency/Special Instructions:

	Breakfast		Lunch		Dinner		Bedtime:	
	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials
MONDAY	☐		☐		☐		☐	
TUESDAY	☐		☐		☐		☐	
WEDNESDAY	☐		☐		☐		☐	

2. MEDICATION: Dosage:

Condition treated:_____ Frequency/special instructions:

	Breakfast		Lunch		Dinner		Bedtime:	
	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials
MONDAY	☐		☐		☐		☐	
TUESDAY	☐		☐		☐		☐	
WEDNESDAY	☐		☐		☐		☐	

3. MEDICATION: Dosage:

Condition treated:_____ Frequency/special Instructions:_____

	Breakfast		Lunch		Dinner		Bedtime:	
	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse initials	To Be Taken	Time Given& Nurse Initials	To Be Taken	Time Given& Nurse Initials
MONDAY	☐		☐		☐		☐	
TUESDAY	☐		☐		☐		☐	
WEDNESDAY	☐		☐		☐		☐	

Nurse Name printed:_____ Nurse signature:_____ Nurse Initials:_____

** Check any of the following that apply:

☐ **Tylenol/ Ibuprofen** may be administered by the 4-H Youth Development event personnel.

☐ **Benadryl** may be administered by the 4-H Youth Development event personnel.

CHILD'S NAME:_____ **PARENT/GUARDIAN** PRINTED NAME:_____

PARENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Comments/instructions may be added to the back of this form.