

# CAMP CAYUGA

## CAMP MEDICATION FORM

BUSINESS OFFICE: Camp Cayuga, PO Box 151, Peapack, NJ 07977 USA. (908) 470-1224  
 SUMMER ADDRESS: Camp Cayuga, 321 Niles Pond Road, Honesdale, PA 18431. (570) 253-3133.  
 Email: info@campcayuga.com. Website: www.campcayuga.com

FOR OFFICE USE ONLY:

<input type="checkbox"/> Confirmed Meds
<input type="checkbox"/> Inaccurate: _____
<input type="checkbox"/> Health Record: _____
<input type="checkbox"/> MARS: _____
<input type="checkbox"/> Data Base: _____
<input type="checkbox"/> JC or OTC
<input type="checkbox"/> _____

**LAST NAME** (print): \_\_\_\_\_ **FIRST NAME:** \_\_\_\_\_

**Check One**  Camper, or  Staff Member.

**Session:**  Full,  First 6-Weeks,  Last 6-Weeks,  First-Half,  Middle-Half,  Second-Half,  Other: \_\_\_\_\_

**Mini-Sessions:**  First 2-weeks,  Second 2-weeks,  Third 2-weeks,  Last 2-weeks.

**INSTRUCTIONS:** If your child is bringing medication to camp (prescription meds, over-the-counter meds, and vitamins), please refer to your Parent Handbook, which explains the camp's policy about medications and packaging meds. Your child's meds are to be placed inside one clear plastic zip-lock baggie, labeled with your camper's name and birth date. The Camp Medication Form is an inventory list of the meds your child is bringing to camp. Complete this form at the time you package your child's meds for camp, and place it inside the baggie with the meds. The meds you list on the Camp Medication Form must coincide with the meds inside the baggie. Do not mail this form to us. Note: When you completed the Health History section online, you listed meds your child was "currently taking" at the time. The Camp Medication Form serves a different purpose - it's simply an inventory list of meds your child is bringing to camp. Reminder: Do not send "gummy-type" vitamins/pills.  CHECK HERE IF MEDICATIONS ARE LISTED ON REVERSE SIDE.

**NAME OF MEDICATION:** (print) \_\_\_\_\_

CHECK  ALL BOXES THAT APPLY TO THIS MEDICATION.

Prescription medication.  
 Over-the-counter medication or  Vitamin.  
 Taken on a routine basis.  Taken on an as-needed basis.  
 Prescribed for a chronic illness or condition.  
 EpiPen held on person.  Inhaler held on person.

STAFF ONLY:  The use (or non-use) of this med could impair my ability to perform essential functions of my job.

Complete below as per original container's label:

Dosage: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_  
 Purpose: \_\_\_\_\_  
 \_\_\_\_\_  
 Comments: \_\_\_\_\_

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