Scheduled Medication Form

Child's Name: _____

- To be completed by Parent/Guardian for all scheduled medications
- One medication and treatment per form
- Parent/Guardian to review at end of treatment
- This record will be kept in child's file

Name of Medication: _____

Dosage: _____

Description:

☐ Tablet ☐ Capsule ☐ Liquid ☐ Spray/Inhalant ☐ Other

Start Date: _____ End Date: _____

Storage Instructions:

_____

_____

Administration Instructions:

_____

_____

STOP the medication/treatment if:

_____

_____

_____

I release Salem Acres Bible Camp and its employees/volunteers from any liability, however caused, arising out of administering or failure to administer, the medication provided herein.

Parent/Guardian Name: _____

Signature: _____

Date: _____