



Medication Form

E3 Discipleship Camp

June 26-28, 2026

NOTE: All Campers must complete this form regardless of daily prescribed medications.

Name of Camper: _____ Camper Date of Birth _____

Medication allergies: _____

All medication to be taken at camp must be given to the camp nurse(s) at check-in. (If under the age of 18.) The nurse(s) will be responsible for proper medication storage and ensuring that your camper gets it.

Please record below what medications to be administered at camp:

	Medication	Dose / Frequency	Time (AM/PM)	Indication	Initials
1					
2					
3					
4					
5					

NOTE: Campers with history of:

- anaphylaxis should bring their own epipen and carry it with them at all times.
- exercise-induced asthma should carry their inhaler with them during competitions or strenuous camp activity.
- insulin-dependent diabetes should discuss with nurse(s) their insulin regimen and blood sugar monitoring plan.

Nurses will provide any over-the-counter prn medications (listed below) and these should not be packed with your camper. Please indicate which over-the-counter medication may be given to your camper as needed.

- Ibuprofen (Advil) 400-600mg
- Acetaminophen (Tylenol) 650mg
- Antacid chewable, 2 tabs
- Diphenhydramine HCL (Benadryl) 25-50mg
- Loratadine 10mg

I hereby give permission for FCA staff/volunteer nurse to give my child medication at camp as instructed above.

Date: _____ Parent/Guardian signature: _____

-For RN Use Only-

Prescription Administration Record:

The below chart is a record of the prescription medication, dose, frequency, time for each medication given at camp administered by camp RN/Staff per parent/guardian request.

	Medication	Dose	Date	Time (AM/PM)	Indication	Initials
1						
2						
3						
4						
5						
6						

RN/Staff Signature: _____

OTC Medication Administration Record:

The below chart is a record of the over the counter medication, dose, frequency, time and why each medication was administered by camp RN/Staff. See front page for medications available.

	Medication	Dose / Frequency	Time (AM/PM)	Indication	Initials
1					
2					
3					
4					
5					

RN/Staff Signature: _____

Notes:
