

**St. Lawrence University/Summer Programs
MEDICATION FORM**

Camp Name: _____

INDIVIDUALIZED ORDERS for: Name _____

DOB: _____ Weight: _____

Standard Over the Counter/PRN Medications (will be administered at the discretion of the camp's medical staff, if approval is indicated by the camper's healthcare provider.):

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and Indications		Comments

Prescription Medications (Please complete with patient's current regimen for both scheduled and pm medications use 2nd page if needed)

Drug	Route	Dosage	Schedule and Indications	Comments

Camper's Health Care Provider Name: _____

Phone: _____

Address: _____

License # _____

Physician Signature: _____

Date: _____

Camper's Parent or Legal Guardian Name: _____

Signature: _____

Date: _____