



**Easterseals Camp Stand By Me**

**Physician MAR Form**

\*Parents take to Physician and get it filled out, signed and dated

<b>Medication Administration Record</b>	Camper Full Name: _____
PAGE ONE	Camper Birthdate: ____/____/____
<p><b>Parents/Guardians:</b> Please fill in medication name/dose/# of pills/time given in blocks on left only and campers' name and birthdate on each page. Medications must be <b>IN ORIGINAL CONTAINERS</b> or in blister packs. Please include inhalers, epi-pens, and any other rescue medication that may be needed. Prescription bottles should correspond to information on this document. Store medication bottles and/or blister packs in a bag or larger container with camper name and date of birth clearly labeled.</p>	
<p><b>Authorized Prescriber:</b> Please confirm medication dosage, quantity, route, and time given. List dosage per tablet or pill, quantity of pills, and total dosage. <b>Please list different dosages of the same medication in consecutive squares.</b> Please fill in name/signature/date/contact information and sign and date each additional page.</p>	
<p><b>Camp Nurse:</b> The <u>date</u> and <u>initial</u> blocks are for you to chart when medication was passed. <u>Sign form below as well.</u> (Missing dose legend: R= refused, S= skipped dose for medical reason)</p>	

Medication Information	Time Given	Day 1:	Day 2:	Day 3:	Day 4:	Day 5:	Day 6:	Day 7:	Day 8:	Medication Waiver (Medication not brought to Camp)
Standard Med Pass Times: 0830/1230/1730/2000 Time/Date										
Medication Name:										Parent Initials:
Dose per tab/pill/ml:										Nurse Initials:
# of tabs/pills/ml:										
Total dosage:										
Route:										
Medication Name:										Parent Initials:
Dose per tab/pill/ml:										Nurse Initials:
# of tabs/pills/ml:										
Total dosage:										
Route:										
Medication Name:										Parent Initials:
Dose per tab/pill/ml:										Nurse Initials:
# of tabs/pills/ml:										
Total dosage:										
Route:										
Medication Name:										Parent Initials:
Dose per tab/pill/ml:										Nurse Initials:
# of tabs/pills/ml:										
Total dosage:										
Route:										
Physician/NP Print Name:										
Physician/NP Signature:										
Date of Signature:										
Contact Number:										

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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<b>Medication Administration Record</b>		Camper Full Name: _____									
ADD-ON PAGE		Camper Birthdate: ____/____/____									
<b>Medication Information</b>		Time Given	Day 1:	Day 2:	Day 3:	Day 4:	Day 5:	Day 6:	Day 7:	Day 8:	Medication Waiver
Standard Med Pass Times: 0830/1230/1730/2000 Time/Date											
Medication Name:											Parent Initials:
Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
Route:											
Medication Name:											Parent Initials:
Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
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# of tabs/pills/ml:											
Total dosage:											
Route:											
Medication Name:											Parent Initials:
Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
Route:											
Physician/NP Signature:											Date:

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_