



Easterseals Camp Stand By Me

Physician MAR Form

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

Medication Administration Record	Camper Full Name: _____
PAGE ONE	Camper Birthdate: ____/____/____
<p>Parents/Guardians: 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 IN ORIGINAL CONTAINERS 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>Authorized Prescriber: Please confirm medication dosage, quantity, route, and time given. List dosage per tablet or pill, quantity of pills, and total dosage. Please list different dosages of the same medication in consecutive squares. Please fill in name/signature/date/contact information and sign and date each additional page.</p>	
<p>Camp Nurse: 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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Medication Administration Record Camper Full Name: _____
ADD-ON PAGE Camper Birthdate: ____/____/____

Medication Information		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:											
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Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
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Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
Route:											
Physician/NP Signature:						Date:					

Camp Nurse Signature: _____ Date: _____