



PLEASE RETURN TO:

WINTER (September 1 - May 1)
P.O. Box 880449, Boca Raton, FL 33488
p: 800-494-6238 f: 561-883-6490

SUMMER (May 1 - August 31)
700 Churchill Street, Pittsfield, MA 01201
p: 413-447-8900 / 800-494-6238
f: 413-447-8905

MEDICATION INSTRUCTION FORM

Camper's Name _____
First, Last (Please Print)

Age _____ Division _____ Date of Birth _____

Routine Medications: Please list below all medications that your child will be taking on a daily basis.
Please include any eye drops, vitamins, topical creams, etc. that you will be sending to camp for daily use.

Table with 4 columns: Name of Medication, Dosage, Frequency, Reason for Medication. Rows 1-4.

Medications to be taken only as needed:

Table with 4 columns: Name of Medication, Dosage, Frequency, Reason for Medication. Rows 1-4.

Does your child take allergy shots? [] Yes [] No If so, when was the last one given prior to camp? _____

When is the next injection due? (day and date please) _____

Please list below allergy shots to be given, frequency and details:

Allergy Doctor's Name _____ Phone () _____

Parent's Signature _____ Date _____

I authorize medication to be given as listed above.