Camp Medical Log

THIS FORM IS TO BE FILLED OUT FOR EACH REGISTRATION SESSION. PLEASE PRINT LEGIBLY.

Child's Name:	Date of Birth:
Parent/Guardian:	
Phone:	Alt. Phone:

OPTIONAL MEDICAL INFORMATION:

List any medical concerns that might affect your ability to participate and/or information you wish us to pass on to EMS or hospital staff in case of emergency:

_____

_____

PLEASE COMPLETE THIS SECTION IF YOU ARE PROVIDING PRESCRIPTION OR OVER-THE-COUNTER MEDICATION(S).

Session Date:									
Medication:		Dosage:		Time taken:					
Side effects/concerns:									
Prescribing Doctor's Name:				Ph. #					
Mon		Tues		Wed		Thurs		Fri	
Time	Staff	Time	Staff	Time	Staff	Time	Staff	Time	Staff

Session Date:									
Medication:		Dosage:		Time Taken:					
Side effects/concerns:									
Prescribing Doctor's Name:				Ph. #					
Mon		Tues		Wed		Thurs		Fri	
Time	Staff	Time	Staff	Time	Staff	Time	Staff	Time	Staff

I give permission to the staff of Charleston County Park & Recreation Commission to administer the medications listed below to my child/minor.

_____ _____

Parent/Guardian Signature Date

Last revised 5-17