

Routine Drug Administration Record

Name: _____ Campsite: _____

Unit Number: _____ Date of birth: _____ Classification: _____

Drug Hypersensitivity: _____ Weight _____

Prescribing Physician: _____ Medication: _____ Rx: No Yes Number: _____ Dosage: _____ Date Filled: _____ Route: P.O . I.M. S.C. S.I. Topical Inhalation Rectal Time: PRN Daily BID TID QID AC PC HS Amount in bottle: _____ Comments: _____ _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: small;">Med Time</th> <th style="font-size: x-small;">S</th> <th style="font-size: x-small;">M</th> <th style="font-size: x-small;">T</th> <th style="font-size: x-small;">W</th> <th style="font-size: x-small;">R</th> <th style="font-size: x-small;">F</th> <th style="font-size: x-small;">S</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Med Time	S	M	T	W	R	F	S																																
Med Time	S	M	T	W	R	F	S																																		

Prescribing Physician: _____ Medication: _____ Rx: No Yes Number: _____ Dosage: _____ Date Filled: _____ Route: P.O . I.M. S.C. S.I. Topical Inhalation Rectal Time: PRN Daily BID TID QID AC PC HS Amount in bottle: _____ Comments: _____ _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: small;">Med Time</th> <th style="font-size: x-small;">S</th> <th style="font-size: x-small;">M</th> <th style="font-size: x-small;">T</th> <th style="font-size: x-small;">W</th> <th style="font-size: x-small;">R</th> <th style="font-size: x-small;">F</th> <th style="font-size: x-small;">S</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Med Time	S	M	T	W	R	F	S																																
Med Time	S	M	T	W	R	F	S																																		

Prescribing Physician: _____ Medication: _____ Rx: No Yes Number: _____ Dosage: _____ Date Filled: _____ Route: P.O . I.M. S.C. S.I. Topical Inhalation Rectal Time: PRN Daily BID TID QID AC PC HS Amount in bottle: _____ Comments: _____ _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: small;">Med Time</th> <th style="font-size: x-small;">S</th> <th style="font-size: x-small;">M</th> <th style="font-size: x-small;">T</th> <th style="font-size: x-small;">W</th> <th style="font-size: x-small;">R</th> <th style="font-size: x-small;">F</th> <th style="font-size: x-small;">S</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Med Time	S	M	T	W	R	F	S																																
Med Time	S	M	T	W	R	F	S																																		

Prescribing Physician: _____ Medication: _____ Rx: No Yes Number: _____ Dosage: _____ Date Filled: _____ Route: P.O . I.M. S.C. S.I. Topical Inhalation Rectal Time: PRN Daily BID TID QID AC PC HS Amount in bottle: _____ Comments: _____ _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="font-size: small;">Med Time</th> <th style="font-size: x-small;">S</th> <th style="font-size: x-small;">M</th> <th style="font-size: x-small;">T</th> <th style="font-size: x-small;">W</th> <th style="font-size: x-small;">R</th> <th style="font-size: x-small;">F</th> <th style="font-size: x-small;">S</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Med Time	S	M	T	W	R	F	S																																
Med Time	S	M	T	W	R	F	S																																		

Initial	Signature	Name	Position

Instructions: Record on this form all medicines brought to camp. You can list up to four medications on each sheet. Record dispensing times and dates in the spaces provided.