easterseals
taking on disability together

Easterseals Camp Stand By Me

Physician MAR Form

FORM MUST BE SIGNED AND DATED BY PHYSICIAN

Medication Administration Record Camper Full Name: ________________________

PAGE ONE Camper Birthdate: ________/______/__________

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.

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.

Camp Nurse: The date and initial blocks are for you to chart when medication was passed. Sign form below as well. (Missing dose legend: R= refused, S= skipped dose for medical reason)

Medication Information Standard Med Pass Times: 0830/1230/1730/2000 Time/Date		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)**
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 ADD-ON PAGE		Camper Full Name: ________________________ Camper Birthdate: ________/______/__________									
Medication Information Standard Med Pass Times: 0830/1230/1730/2000 Time/Date		Time Given	Day 1:	Day 2:	Day 3:	Day 4:	Day 5:	Day 6:	Day 7:	Day 8:	**Medication Waiver**
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:											
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Dose per tab/pill/ml:											Nurse Initials:
# of tabs/pills/ml:											
Total dosage:											
Route:											
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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: _______________