

Congregation Beth Am
Youth Retreat
Camper Prescription and OTC medications

Please note that this completed form must accompany the camper at Retreat check-in with all medications to be dispensed during the Youth Retreat.

Camper Name: (print clearly) _____

1) Medication: _____ Dosage: _____
Taken for: _____
Taken: _____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other (indicate time)

2) Medication: _____ Dosage: _____
Taken for: _____
Taken: _____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other (indicate time)

3) Medication: _____ Dosage: _____
Taken for: _____
Taken: _____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other (indicate time)

4) Medication: _____ Dosage: _____
Taken for: _____
Taken: _____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other (indicate time)

(Please list any additional medications including dosages and times to be taken.)

In case of minor headaches, allergies or cold symptoms the Camp Medical personnel or Senior Retreat Staff member may give my child OTC non-aspirin medications.

Circle one: YES NO

Parent or Guardian Signature: _____

Date: _____