



TVR Christian Camp & Retreat Center

P.O. Box 10, Plumptree NC 28664 • 828.765.7860 • 828.765.0690 fax • information@tvr.org

MEDICATION FORM

While your child is here for summer camp we want to make sure that you are able to rest at ease in knowing that your camper is well taken care of. Each week of summer camp we have a staff member who administers all camper meds and assesses all injuries. In our medical closet we carry a wide variety of over the counter medications such as allergy meds, pain relievers, ointments, and stomach meds. **Please do not send these items to camp with your child, as well as non-essential (for the week) vitamins and supplements.**

We ask that you fill out the form below and place it in a Ziploc bag ready **to turn in to camp staff on registration day.** **Please do not send form in before check-in.** ALL medicine must be filed and turned in to our staff on the Monday of camp. For those with inhalers, we will discuss the best options for your child with you and our staff.

If you have further questions concerning medications, please feel free to contact Shelia at 828.765.7860, or email her at soakley@tvr.org.

Camper Name: _____

Age Group: Circle One

Pioneer (3rd-5th grade)

Ranger (6th-8th grade)

Mountaineer (9th-12th grade)

Please list **all** medication taken routinely. Bring enough medication to last during the entire stay at camp. Please clearly and accurately label medication if not in original packaging, so that the label identifies the name of the medication, the dosage, and the frequency of administration. If at all possible, it is much more feasible on our end to administer bedtime medications at dinner time, if the medication allows for flexibility in administration time (allergy meds, over-the-counter drugs, etc.). This request is due to the volume of campers and medications dispensed, along with the campers' schedule later in the evening. It makes for a smoother process to administer as many medications earlier in the evening as possible.

Please be as clear as possible as to dosage and timing of administration.

Med #1 _____ Dosage _____ Circle one : AM PM BT

Med #2 _____ Dosage _____ Circle one : AM PM BT

Med #3 _____ Dosage _____ Circle one : AM PM BT

Parent/Guardian Signature: _____

****For Office Use Only****

Counselor Name: _____

Rooming Assignment: _____