Pioneer Day Camp Nurse
Medical Information

Last Name: _____First Name: _____

Tribe: _____

DAY	SITUATION	DATE	TIME	PROCEDURE TAKEN
SUNDAY				
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				

Remarks:

_____
_____
_____
_____
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_____
_____
_____

******BELOW TO BE FILLED OUT BY PARENTS******

List any uncontrolled or over-the-counter drugs that your child <u>cannot</u> consume:

_____
_____
_____
_____

List any controlled or prescription drugs that your child has to consume and the procedure in which they should be taken:

_____
_____
_____
_____