

Fall Spring
20 _____

OUTDOOR SCHOOL MEDICATION LOG

Teacher: Please complete and give to camp nurse with medications.

SITE: ASR AW HO CG WEEK: 0 1 2 3 4 5 6 7 8 9 10 SCHOOL: _____ TEACHER: _____

STUDENT NAME	MEDICATION	Teacher Check - In		Teacher Check-out	
		Initial	Date	Initial	Date
	Note: 1 entry per line				
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

RN SIGNATURE _____ DATE _____

Is there food or equipment to be returned to families? Teacher initial if items have been picked up. _____

SITE NURSE: RETURN TO OUTDOOR SCHOOL PROGRAM NURSE AT END OF EACH WEEK