Achievement Centers for Children: Camp Cheerful **Medication/Treatment Administration Record (MAR/TAR)**

****Medications must be in original container, with doctor's directions if it is prescription (no "loose" pills in bags or dispensers).**		
Camper name:	**Date of birth:**	**Session dates:** *(include year)*
Transcribed by: **Date:**	**Allergies:**	**Camp** *(check one)* ☐ Cheerful Day Camp ☐ Summer Overnight ☐ Extended School Year (ESY) ☐ Weekend Overnight
Special instructions:		**Cabin/Group:**

A: When the medication is given, write the time of administration and initial
B. When the medication is NOT given, use the appropriate abbreviation and initial
C. State reason for NOT administering (back)
D. Sign full name on back of the form
E. PRNs: Reason given and results must be noted on the back of the form
Legend: A= Absent; C= Closed; MNR= Medication Not Received

Check IN amt./#	Check OUT amt./#	Medication	Time to be administered (AM/PM)	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
				Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
		Name:															
		Strength (ex. "200mg"):															
		Type (tablet, solution, etc.):															
		Dose (ex. "2 capsules"):															
		Route (oral, topical, etc.):															
		Name:															
		Strength (ex. "200mg"):															
		Type (tablet, solution, etc.):															
		Dose (ex. "2 capsules"):															
		Route (oral, topical, etc.):															
		Name:															
		Strength (ex. "200mg"):															
		Type (tablet, solution, etc.):															
		Dose (ex. "2 capsules"):															
		Route (oral, topical, etc.):															
		Name:															
		Strength (ex. "200mg"):															
		Type (tablet, solution, etc.):															
		Dose (ex. "2 capsules"):															
		Route (oral, topical, etc.):															

Check IN
Camper/Parent/ Guardian Signature: _____ Date: _____
Recreation Staff Signature: _____ Date: _____

Check OUT
Camper/Parent/ Guardian Signature: _____ Date: _____
Recreation Staff Signature: _____ Date: _____

BLUE - A.M. **GREEN - LUNCH** **PINK - DINNER** **ORANGE - P.M.** **PURPLE - SPECIAL TIME**

Camper name:

Date of birth:

PRN/As Needed Medications and/or Routine Medications Not Administered

Date	Time	Initials	Medication	Reason	Result

Medication Administration Personnel *Camp Nurses or DODD Medication Administration-Certified Staff Only		
Print name	Signature	Initials

Notes