Youth Name: _____

CPLC Youth For Life - Supplemental Medical Information

Known Drug Allergies: _____

Chronic Conditions (Including Mental Health Conditions): _____

_____

Other Pertinent Medical Information: _____

_____

My child takes the following daily medications:

Prescription

Medication	Reason for Medication	Dosage	Frequency	Time Taken

Over the Counter

Vitamins

I understand that I need to turn in all medications, including vitamins, to the camp staff and a staff member will dispense the stated dosage to my child each day.

_____

Print Name of Parent

_____ _____

Signature Date