Medication Form – Troop 211

Boy Scouts of America / Chippewa District / Great Lakes Council

Use one form per medication

Camper's Name:	DOB:					
Parent / Guardian:	Phone:					
Doctor's Name:	Phone:					
Medication/Strength:	Qty Needed:					
Reason for Medication :						
Administration Schedule:						
When was medication started?	Temporary Permanent					
Side Effects (reactions, stress, motor activity, concentration,	drowsiness, lethargy, etc.):					
List other important information about this medication:						
Special Storage Instructions:						
Action Needed if Not Taken:						
Waiver: This information is confidential and is provided to for the purpose of helping to ensure a healthy, safe camping shared with medical personnel should the necessity arise.						
Signature of Parent/Guardian	Date					

Administration Record – Additional Notes on Back

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials