TROOP # ______________________________ SITE ________________________

BAY-LAKES COUNCIL BOY SCOUTS OF AMERICA

MEDICATION CARD

Scout's Name ____________________________________ Parent's Signature _______________________________

Address ____ Phone ____________________

Name of drug and dosage ____

Date medication is to begin ____

Possible side effects of medication ____

Time of administration ____

I agree to be available for direct communication from the person dispensing or administering the medication. Specific conditions under which I should be contacted regarding the conditions or reactions of the Scout receiving the medication are:

____

____

____

____

____

____

Physician's Signature ____________________________________

Address ____________________________ Phone ____________

This card must be completed by the Physician and Parent. The card MUST be brought to camp with any medication. No medicine container will be accepted at camp unless it is in the container dispensed by the pharmacist and the name of the patient, the name of the personal physician, the prescription number, the date dispensed, the name of the medicine and directions for use are on the container.

HEALTH OFFICE USE	
DATE	REVIEWED BY

TROOP # ______________________________ SITE ________________________

BAY-LAKES COUNCIL BOY SCOUTS OF AMERICA

MEDICATION CARD

Scout's Name ____________________________________ Parent's Signature _______________________________

Address ____ Phone ____________________

Name of drug and dosage ____

Date medication is to begin ____

Possible side effects of medication ____

Time of administration ____

I agree to be available for direct communication from the person dispensing or administering the medication. Specific conditions under which I should be contacted regarding the conditions or reactions of the Scout receiving the medication are:

____

____

____

____

____

____

Physician's Signature ____________________________________

Address ____________________________ Phone ____________

This card must be completed by the Physician and Parent. The card MUST be brought to camp with any medication. No medicine container will be accepted at camp unless it is in the container dispensed by the pharmacist and the name of the patient, the name of the personal physician, the prescription number, the date dispensed, the name of the medicine and directions for use are on the container.

HEALTH OFFICE USE	
DATE	REVIEWED BY

MEDICATION CARD - SIDE 2
(Side 2 - camp use only)

SCOUT'S NAME ____

Initial; fill in date and time whenever medication is administered.

DATE	TIME	INITIALS	DATE	TIME	INITIALS	DATE	TIME	INITIALS

Full name of person(s) responsible for administering medication.

________________________________ ________________________________ ________________________________

MEDICATION CARD - SIDE 2
(Side 2 - camp use only)

SCOUT'S NAME ____

Initial; fill in date and time whenever medication is administered.

DATE	TIME	INITIALS	DATE	TIME	INITIALS	DATE	TIME	INITIALS

Full name of person(s) responsible for administering medication.

________________________________ ________________________________ ________________________________