Troop 380 – Boy Scouts of America

Participants Name____

Medication Form

Unit:

INSTRUCTIONS 1. ALL Participants MUST complete and submit a signed copy of this form, even if no medications are provided. 2. Medication (Prescription and Over-The-Counter) must be in ORIGINAL labeled container and placed in zip-lock type bag identified with Scout's name. 3. Any Medications unclaimed at the conclusion of the event will be destroyed. Check No Medications are to be given (including Over-The-Counter). Authorize Administration of Medications as Indicated Signed (Parent or Guardian) (NOTE: Good for 1 year from signature date.)	Over-The-Counter Medications: Ibprofen, Acetaminophen, Antacid, Decongestant, Calamine, (NOTE: Circle what applies, List Others that are also provided) Strength Age/weight appropriate Frequency As directed by Manufacture Any Special Reason for taking this medication
Medication: Strength Frequency Reason for taking this medication Approximate date started: Temporary Permanent Side Effects: Storage Instructions: Prescribing Physician: Physicians Phone	Medication: Strength Frequency Reason for taking this medication Approximate date started: Temporary Permanent Side Effects: Storage Instructions: Prescribing Physician: Physicians Phone
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