Medication Form – Troop 957

Boy Scouts of America / Bayshore District / Sam Houston Area Council

Use one form per medication – copy as needed – continue on back if required

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 experience for my child. This form may be 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