

MEDICATION FORM

(one form per medication, copy as needed)

Unit #: _____ District: _____ Council: _____

Camper's Name: _____

Name of Parent or Guardian: _____ Phone () _____

Doctor's Name: _____ Phone () _____

Medication/Strength: _____

Reason for medication _____

Expected Schedule: (i.e. 3 times a day, As needed, etc.) _____

When was medication started? _____ Temporary _____ Permanent _____

Side Effects (reactions to food, dehydration, stress, iodine, other meds., decreased balance, motor activity, concentration, drowsiness, lethargy, etc. _____

List other important information about this medication since access to medical information or facilities could be delayed due to geographical area.

Special Storage instructions _____

Expected action if medicine is not taken as directed _____

Total quantity needed _____

Waiver: This information is confidential and is provided to _____

Name of Leader

For the express 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. It will be returned to me at the end of the trip.

Signature of Parent/Guardian _____ Date _____

PHOTOCOPY AS REQUIRED