

Unit Number 81 Site \_\_\_\_\_

### MEDICATION CARD

Boy Scouts of America

Scout's Name \_\_\_\_\_ Parent's Signature \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of drug and dose \_\_\_\_\_

Date medication is to begin \_\_\_\_\_

Purpose of medication \_\_\_\_\_

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 condition or reactions of the Scout receiving the medication are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This card must be completed by the \_\_\_\_\_ parent. The card must be brought to camp with any medications. 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 label.

HEALTH OFFICE USE:

Date: \_\_\_\_\_ Reviewed By: \_\_\_\_\_

X \_\_\_\_\_

Parents Signature

Medication Card - Side 2			Scout's Name _____					
(Camp use only!!)								
Fill in date, time, and initial whenever medication is administered.								
Date	Time	Initial	Date	Time	Initial	Date	Time	Initial
Full name of person(s) responsible for administering medication:								
_____								