

MEDICATION FORM
(One form per medication, copy as needed)

Unit # _____ District: _____ Council _____

Camper's Name _____

Name of Parent or
Guardian: _____Phone Numbers: (H) _____
(B) _____

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, decrease 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 _____