



Troop 4
MEDICATION CARD



| | | | |
|---------------------------|----------------|--------------------|------|
| Scout's Name: | | Parent's Signature | Date |
| Telephone Numbers (Home): | | (Work): | |
| Scout's Age | Scout's Weight | Scout's Height | |

BRAND NAME OR GENERIC DRUG ADMINISTRATION

[please circle those for which you give permission and strike-out those for which you do not give permission]

For minor conditions, **I authorize the adult Safety Officer or senior registered adult leader to administer the drugs designated by me** in the Brand Name or Generic Drug Administration section of this form.

| | | | |
|----------------|-----------------|------------------------|---------------------|
| Advil | Benadryl | Caladryl | Neosporin |
| Tylenol | Sudafed | Calamine Lotion | Pepto-Bismol |

Special Instructions

ROUTINE DRUG ADMINISTRATION RECORD

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| <p>I agree to be available for direct communication from the person dispensing or administering the medications(s) listed in the Drug Administration Record below. Specific conditions under which I should be contacted regarding the condition or reactions of the Scout receiving the medication(s) are:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Physician's Signature _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Telephone No.(s) _____</p> | <p>This card must be completed by the <u>physician and parent</u>. The card must be brought to camp with any medication. 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 container.</p> <p>In the event of an emergency when I or a designated contact cannot be reached, the adult Safety Officer or senior registered adult leader at the campout (activity) is authorized to act in my behalf at his/her discretion.</p> |
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Safety Officer: Fill in date, time and initial whenever medication is administered

Medication: _____ Rx No: _____
 Prescribing Physician: _____
 Amount in bottle: _____ Dosage: _____
 Times: PRN Daily BID QID AC PC HS
 Comments:

| | | | | | | | |
|----------|---|---|---|---|---|---|---|
| MED TIME | S | M | T | W | T | F | S |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Medication: _____ Rx No: _____
 Prescribing Physician: _____
 Amount in bottle: _____ Dosage: _____
 Times: PRN Daily BID QID AC PC HS
 Comments:

| | | | | | | | |
|----------|---|---|---|---|---|---|---|
| MED TIME | S | M | T | W | T | F | S |
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| | | | | | | | |

Medication: _____ Rx No: _____
 Prescribing Physician: _____
 Amount in bottle: _____ Dosage: _____
 Times: PRN Daily BID QID AC PC HS
 Comments:

| | | | | | | | |
|----------|---|---|---|---|---|---|---|
| MED TIME | S | M | T | W | T | F | S |
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