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.

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

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Special Storage instructions:

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Expected action if medicine is not taken as directed

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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__________________