Bay-Lakes Council Boy Scouts of America

MEDICATION CARD

Unit number ______________ Site ______________________________

Scout's Name ______________________________

Address ______________________________ Phone # ______________

Name of drug & dose ______________________________

Date medication is to begin ______________ Time of administration ________ AM / PM

Purpose of medication ______________________________

Possible side effects of medication ______________________________

I agree to be available for direct communication from the person dispensing/administering the medication. Specific conditions under which I should be contacted regarding the condition or reactions of the Scout receiving the medication are:

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This card must be completed by the parent or guardian. The card **must** be brought to camp with any medications. No medicine container will be accepted at camp unless it is in the original container with the name of the patient, physician, prescription number, the date dispensed, name of medicine, and directions for use on the label.

HEALTH OFFFICE USE:

Date: ______________ Reviewed by: ______________

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Parent Signature

Bay-Lakes Council Boy Scouts of America

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Scout's Name ______________________________

Address ______________________________ Phone # ______________

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HEALTH OFFFICE USE:

Date: ______________ Reviewed by: ______________

____

Parent Signature

Medication Card – Side 2
(Camp use only!!!!)

Scout's Name ______________________________

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:

______________________ ______________________ ______________________

Medication Card – Side 2
(Camp use only!!!!)

Scout's Name ______________________________

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:

______________________ ______________________ ______________________