



**BOY SCOUT OF AMERICA
TROOP 328
ALLEN, TEXAS**

MEDICATION FORM

(One form per medication, copy as needed)

Council Circle Ten District Arrowhead

Camper's Name _____

Name of Parent or Guardian _____ Phone (____)

or (____)

Doctor's Name _____ Phone (____)

Medication / Strength _____

Reason for Medication _____

When was medication started? _____ Temporary _____ Permanent

Side Effects (reactions to food, dehydration, stress, iodine, other medications, decreased balance, motor activity, concentration, drowsiness, lethargy, etc.)

List other important information about medication since access to medical information or facilities could be delayed 6-10 hours due to remote setting.

Special storage instructions

Expected action if medicine is not taken as directed

Total quantity needed

Waiver: This information is confidential and is provided to _____

Advisor's Name

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 _____

PHOTOCOPY AS REQUIRED

Updated 5/14/04