

PRESCRIPTION MEDICATION INFORMATION FORM

Unit # _____ Council: _____

Camper's Name: _____

Name of Parent or Guardian: _____ Phone: (____) _____

Prescribing Doctor's Name: _____ Phone: (____) _____

Medication / Strength: _____

Reason for medication: _____

When was medication started? _____ Temporary Permanent

Side effects (reactions to food, dehydration, stress, iodine, other medication, decreased balance, motor activity, concentration, drowsiness, lethargy, etc): _____

Special Storage Instructions: _____

Expected action if medicine is not taken as directed: _____

Total quantity needed for the week: _____

WAIVER: This information is confidential and is provided to _____ (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 or other leaders should the necessity arise. It will be returned to me at the end of camp.

Signature of Parent/Guardian: _____ Date: _____

Procedure:

- One form per prescription medication
- Place the prescription medication form and medication (must be in original container) within a ziplock bag
- Label the ziplock bag with name, address, and troop number

***If a pillbox is used, please include the original container.
Medications will be given only as directed on the original container.***