Unit Number _____ Site _____

Bay-Lakes Council **MEDICATION CARD** Boy Scouts of America

Scout's Name _____ Parent's Signature _____

Address _____ Phone # _____

Name of drug and dose _____

Date medication is to begin _____

Purpose of medication _____

Possible side effects of medication _____

Time of administration _____

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

_____

_____

_____

_____

_____

X _____

Physician's Signature

This card must be completed by the physician and parent. The card must be brought to camp with any medications. 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 label.

HEALTH OFFICE USE:

Date: _____ Reviewed By: _____

Unit Number _____ Site _____

Bay-Lakes Council **MEDICATION CARD** Boy Scouts of America

Scout's Name _____ Parent's Signature _____

Address _____ Phone # _____

Name of drug and dose _____

Date medication is to begin _____

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HEALTH OFFICE USE:

Date: _____ Reviewed By: _____

Medication Card - Side 2 Scout's Name _____
(Camp use only!!)

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 Scout's Name _____
(Camp use only!!)

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:

_____ _____ _____