

Medication Card

Participant's Name: _____ Parent's Signature _____

Address _____

City _____ State _____ Zip _____ Troop # _____

Telephone Numbers (Home) _____ (Cell) _____ (Work) _____

Drug Allergies (Hypersensitivity) _____

<p>I agree to be available for direct communication from the person dispensing or administering the medication(s) listed in the drug administration card below. Specific conditions under which I should be contacted regarding the condition or reactions of the Scout receiving the medication(s) are :</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Physician's Signature _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Telephone No.(s) _____</p>	<p>This card must be completed by the <u>physician</u> and <u>parent</u>. The card must be brought to camp with any medication. <u>No</u> medicine container will be accepted at camp unless it is 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 container.</p>
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Routine Drug Administration Record

(Initial, fill in date and time whenever medication is administered)

Medication: _____ Rx No: _____

Prescribing Physician: _____

Dosage: _____ Date Filled: _____ Route: _____

Times: PRN Daily BID TID QID AC PC HS

Amount In Bottle: _____ Comments: _____

Med Time	S	M	T	W	R	F	S

Medication: _____ Rx No: _____

Prescribing Physician: _____

Dosage: _____ Date Filled: _____ Route: _____

Times: PRN Daily BID TID QID AC PC HS

Amount In Bottle: _____ Comments: _____

Med Time	S	M	T	W	R	F	S

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Times: PRN Daily BID TID QID AC PC HS

Amount In Bottle: _____ Comments: _____

Med Time	S	M	T	W	R	F	S

Full Name of Person(s) Administering Medication

Name	Position	Signature	Initial
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