

## TROOP 50 MEDICATION INFORMATION FORM

SCOUT'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ EVENT: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE (# OF TABLETS, ETC.)	FREQUENCY/ TIME OF DAY	SIDE EFFECTS	ACTIVITY RESTRICTIONS	STORAGE REQUIREMENTS

I hereby authorize the Camp Health Officer or Troop 50 Leaders to administer the above medications to my Scout.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_