CORONADO AREA COUNCIL

MEDICATION FORM

BOY SCOUTS OF AMERICA

MEDICATION MUST BE IN ORIGINAL CONTAINER

(one form per medication, copy as needed)

Unit # _____ District _____ Council _____

Camper's Name _____

Name of Parent or Guardian _____ Phone ( ) _____

Doctor's Name _____ Phone ( ) _____

Medication/Strength _____

Time(s) of Day Medication Taken _____

Amount of Medication Taken _____

Reason for medication _____

_____

When was medication started? _____ Temporary _____ Permanent _____

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

_____

_____

List other important information about this medication since access to medical information or facilities could be delayed due to geographical area. _____

_____

Special Storage instructions _____

_____

Expected action if medicine is not taken as directed _____

_____

Waiver: This information is confidential and is provided to _____

Name of Leader in Camp

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.

Signature of Parent/Guardian _____ Date _____