Sam Houston Area Council – Boy Scouts of America
Medication Form

Participants Name_____Unit:_____

INSTRUCTIONS

1. **ALL Participants *MUST* complete and submit a signed copy of this form, even if no medications are provided.**
2. Medication (Prescription and Over-The-Counter) must be in *ORIGINAL* labeled container and placed in zip-lock type bag identified with Scout's name.
3. Any Medications unclaimed at the conclusion of the event will be destroyed.

Check One:

☐ No Medications are to be given (including Over-The-Counter).

☐ Authorize Administration of Medications as Indicated

_____ _____
Signed (Parent or Guardian) Date
(NOTE: Good for 1 year from signature date.)

Over-The-Counter Medications**:** Ibprofen, Acetaminophen, Antacid, Decongestant, Calamine, _____

_____

_____

(NOTE: Circle what applies, List Others that are also provided)

Strength Age/weight appropriate _____

Frequency As directed by Manufacture _____

Any Special Reason for taking this medication_____

_____

_____

_____

_____

Medication:_____
Strength_____
Frequency_____
Reason for taking this medication_____
_____
Approximate date started:_____
Temporary _____ Permanent_____
Side Effects:_____
_____
Storage Instructions:_____
_____
Prescribing Physician:_____
Physicians Phone_____

Medication:_____
Strength_____
Frequency_____
Reason for taking this medication_____
_____
Approximate date started:_____
Temporary _____ Permanent_____
Side Effects:_____
_____
Storage Instructions:_____
_____
Prescribing Physician:_____
Physicians Phone_____

Medication:_____
Strength_____
Frequency_____
Reason for taking this medication_____
_____
Approximate date started:_____
Temporary _____ Permanent_____
Side Effects:_____
_____
Storage Instructions:_____
_____
Prescribing Physician:_____
Physicians Phone_____

Medication:_____
Strength_____
Frequency_____
Reason for taking this medication_____
_____
Approximate date started:_____
Temporary _____ Permanent_____
Side Effects:_____
_____
Storage Instructions:_____
_____
Prescribing Physician:_____
Physicians Phone_____

(For additional space, copy form and attach together as needed.)