

PRESCRIPTION MEDICATION RECORD

Troop _____	Campsite _____
Scouts Name _____	Parent's Name _____
Address _____	Phone _____
Name of Drug _____	Dosage _____
Medication _____	Strength _____
Reason for medication _____	
When was the medication started? _____ Temporary _____ Permanent _____	
Side effects: (please circle all that apply) reactions to food, dehydration, stress, iodine, other medications, decreased balance, decreased appetite, motor skills, concentration, drowsiness, lethargy, etc.):	
Special storage instructions _____	Quantity In _____ Quantity Out _____
Health Officer Signature _____	Leader Signature _____

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Special storage instructions _____	Quantity In _____ Quantity Out _____
Health Officer Signature _____	Leader Signature _____

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 receiving the medications are: _____

Phone _____ Physician or Parent Signature _____

Make copies as needed.