

TROOP _____ CAMP _____ SITE _____
Tennessee Council

Middle

MEDICATION CARD

Scout's Name _____ Parent's Signature _____

Address _____ Phone _____

Name of drug and dosage _____

Date medication is to begin _____

Purpose of medication _____

Possible side effects of medication _____

Time of administration _____

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 medication are: _____

Physician's Signature _____

Address _____ Phone _____

This card must be completed by the Physician and Parent. The card MUST be brought to camp with any medication. NO medicine container will be accepted at camp unless it is in 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. **HEALTH OFFICE USE**

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