

Troop 565 Medication Release

Adult / Scout Name _____ Age _____ Weight _____
 Emergency Contact #1 _____ Phone (_____) _____--_____
 Emergency Contact #2 _____ Phone (_____) _____--_____
 Doctor's Name _____ Phone (_____) _____--_____
 Food / Drug Allergies? _____

Please complete both parts of this form, where applicable. All Scout Medication MUST be given to the appropriate adult at the start of any event unless special arrangements are made. PLEASE WRITE LEGIBLY.

PART 1) PRESCRIPTION MEDICATION

Please list all Prescription Medication that your scout is required to take on any campout or event, by dosage and when it should be taken. Medication should be in its original container listing Doctor, Pharmacy, and Pharmacy Contact Information.

All Medication is to be held by an Adult Leader / Camp Medical Counselor unless it is critical for the scout to have it on their person for emergency purposes – this should be clearly outlined in the Special Instructions section of this form.

Place Bottles in ONE Ziploc Bag labeled with Scout's Name		Enter Dosages for Appropriate Time**				
Medication Information	Form*	Breakfast 8AM	Lunch 12PM	Dinner 6PM	Bedtime 10PM	Other
Adderall XR 15mg – Take with Food	CPSL	1 PILL		1 PILL		

Special Instructions _____

PART 2) OVER-THE-COUNTER (OTC) MEDICATION

Please indicate which, if any, of the following OTC medication that may be given to your child by an Adult Leader / Camp Medical Counselor. The examples given are not necessary the brand that will be given, but are merely to assist you in choosing.

- | | |
|--|--|
| <input type="checkbox"/> YES / NO <input type="checkbox"/> Aspirin (e.g. Bayer, Bufferin, St. Joseph, etc.) | <input type="checkbox"/> YES / NO <input type="checkbox"/> Decongestant (e.g. Sudafed, Actifed, etc) |
| <input type="checkbox"/> YES / NO <input type="checkbox"/> Acetaminophen (e.g. Tylenol, Excedrine, etc.) | <input type="checkbox"/> YES / NO <input type="checkbox"/> Sore Throat (e.g. Halls, Sucrets etc.) |
| <input type="checkbox"/> YES / NO <input type="checkbox"/> Ibuprofen (e.g. Advil, Motrin, etc.) | <input type="checkbox"/> YES / NO <input type="checkbox"/> Antacid (e.g. Tums, Rolaids, etc) |
| <input type="checkbox"/> YES / NO <input type="checkbox"/> Antihistamine (e.g. Benadryl, Dimetapp, Claritin, etc.) | |

I hereby give my permission to permit any Troop 565 Adult Leader or Camp Medical Counselor to administer the above prescription medication and/or any of the above OTC medication, marked YES, to my child. I understand that the Adult Leaders / Camp Medical Counselors are not liable for any adverse affects that may occur due to this medication and they are not liable in the possibility that a child misses a prescribed dose or in the event the medication is administered incorrectly. I also understand that the Adult Leaders / Camp Medical Counselors are under no obligation to provide any medication to my child if they deem it could be potentially harmful.

I also state that all the above information is complete and accurate and any misapplication of medication due to inaccurate, incomplete, or unreadable information is not the responsibility of the Adult Leader / Camp Medical Counselor. I also understand that the Adult Leaders / Camp Medical Counselors are not responsible if my child fails to present themselves at the announced places / times to receive the above specified medication.

Signature _____ Date ____/____/____
 Parent / Guardian _____

* Form Abbreviation: Tablet = TAB, Caplet = CPLT, Capsule = CPSL, Liquid = LQD, Inhaler = INHL, Cream = CRM, Nasal Spray = NSL
 ** Dosage Abbreviation: Pill = PILL, Teaspoon = TSP, Tablespoon = TBS, Spray = SPRY