

UNIT & NO. \_\_\_\_\_ CAMP \_\_\_\_\_

NAME \_\_\_\_\_

**REQUEST FOR MEDICATION TO BE DISPENSED**

**Please PRINT in ALL information below and sign.**

I, \_\_\_\_\_, (Parent/Guardian), do hereby release from ALL legal responsibility The National Boy Scout Council, The Greater St. Louis Area Council, All Staff and representatives there of, for the dispensing of requested prescription and over the counter medication(s), as prescribed by the physician and myself. I understand that an allergic reaction(s) or complication(s) are possible ANY TIME.

PRESCRIPTION MEDICATIONS:

PRINT: NAME, DOSE, TIME/FREQUENCY to be dispensed. ALL medications must be supplied in ORIGINAL bottle containing the physician directions. NO EXCEPTIONS!!!!!!!

Physician Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_

OVER THE COUNTER MEDICATIONS:

List ALL over the counter medication(s) that may be dispensed, to the individual listed above, for MINOR complaints of: aches, pains, discomfort, diarrhea, nausea, etc. PRINT: NAME, DOSE, TIME/FREQUENCY to be dispensed.

Example:

- a.) Tylenol Extra-Strength – 2 tablets every 4-6 hours as needed
- b.) Motrin 200 mg – 3 tablets every 4-6 hours as needed
- c.) Peptobismal Chewable – 2 tablets every 4 hours as needed

**If NO medication is to be dispensed, please indicate by printing NONE.**

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_
- 5.) \_\_\_\_\_
- 6.) \_\_\_\_\_

BY SIGNING BELOW, YOU AGREE TO AND UNDERSTAND THE PRINTED MATERIAL AND ACCEPT TOTAL RESPONSIBILITY FOR ANY LISTED MEDICATION(S) BEING DISPENSED TO YOUR SCOUT.

Signature \_\_\_\_\_

Witness (2) \_\_\_\_\_

Date and Time \_\_\_\_\_

FORM GOOD UP TO ONE (1) YEAR FROM DATE SIGNED. ANY CHANGES REQUIRE A NEW FORM.

Medication Record - Given to \_\_\_\_\_

	A	B	C	D	E	F
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	DATE	TIME	MEDICATION	DOSAGE	ADULT INITIALS	YOUTH INITIALS
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2						
3						
4						
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