MEDICATION FORM
2003 ORANGE DISTRICT CUB SCOUT DAY CAMP

Request for Administration of Medication
Orange District Cub Scout Day Camp

All medications to be given at camp MUST be turned in DAILY to the CAMP NURSE and will be administered by the nurse. All medication must be CLEARLY LABELED with CHILD'S NAME, DOSAGE AMOUNT, DOSAGE TIME, and DOCTOR'S NAME AND PHONE NUMBER. IT MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER.

To be completed by Physician:

Scout’s Name: ______________________________________

Medication (name) _______________________________ (dose) ______________________________

(No routine injections will be given)

Time(s) to be administered at camp: a.m.:________________ p.m.: ______________ prn: __________

Purpose of medication: ________________________________________________________________

Side effects/contraindications: __________________________________________________________

__________________________________________________________________________________

Termination date (last day of camp unless otherwise indicated): ____________________________

Physician’s Name Printed                                      Physician’s Telephone (REQUIRED)

Physician’s Signature                               Date

To be completed by Parent/Guardian:

I hereby give permission for my child, ____________________________________, to receive

(child’s name) medication during camp hours. All medications, including over-the-counter products, have been prescribed by licensed physician(s). Medications will be furnished in pharmacy-labeled bottles with identifying information. I assume full responsibility for informing the camp of any change in my child’s health and/or medication. I agree that medication dosage cannot be changed without a physician’s order. Further, I understand that the only responsibility or liability that can be assumed by the camp or it’s personnel is to comply with the instructions provided by the scout’s parent and physician.

Parent/Guardian signature                              Date

Parent/Guardian Telephone (REQUIRED): ___________________________

To be completed by Camp Nurse:

Name and title of person to administer medication: _________________________________

Scout’s Den Leader: ___________________________________________