TROOP 50 MEDICATION INFORMATION FORM

SCOUT'S NAME: _____ PHONE: _____ EVENT: _____

PHYSICIAN'S NAME: _____ PHONE: _____ DATE: _____

NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE (# OF TABLETS, ETC.)	FREQUENCY/ TIME OF DAY	SIDE EFFECTS	ACTIVITY RESTRICTIONS	STORAGE REQUIREMENTS

I hereby authorize the Camp Health Officer or Troop 50 Leaders to administer the above medications to my Scout.

SIGNATURE: _____ Date: _____