Golden Spread Council - Boy Scouts of America
Medication Form

Participants Name:__________________________________Unit:_______________

List all Medication Allergies: ____

INSTRUCTIONS

1. **ALL Participants *Must* complete and submit a signed copy of this form, even if no medications are provided.**
2. Medication (prescription and Over-the-Counter) must be in *ORIGINAL* label container and placed in a zip-lock type bag identified with Scout's name and Unit Number.
3. Any Medications unclaimed at the conclusion of the event will be destroyed.

Check One:

- ☐ No Medications are to be given (including Over-the-Counter)
- ☐ Authorize Administration of Medications as indicated

____________________________ __________
Signed (Parent or Guardian) Date

(NOTE: Good for 1 year from signature date.)

Over-the-Counter Medications:
Ibuprofen, Acetaminophen, Antacid, Decongestant, Calamine, Benadryl, Hydrocortisone Cream, Antibiotic Oninment

(NOTE: Circle what applies, list others that are also provided)

Strength Age/weight appropriate

Frequency As directed by Manufacture

Any special reason for taking this medication

Medications: Strength: Frequency: Reason for taking this medication:	Medications: Strength: Frequency: Reason for taking this medication:
Approximate date started: Temporary ____ Permanent ____ Side Effects:	Approximate date started: Temporary ____ Permanent ____ Side Effects:
Storage Instructions:	Storage Instructions:
Prescribing Physician: Physician's Phone:	Prescribing Physician: Physician's Phone:
Medications: Strength: Frequency: Reason for taking this medication:	Medications: Strength: Frequency: Reason for taking this medication:
Approximate date started: Temporary ____ Permanent ____ Side Effects:	Approximate date started: Temporary ____ Permanent ____ Side Effects:
Storage Instructions:	Storage Instructions:
Prescribing Physician: Physician's Phone:	Prescribing Physician: Physician's Phone:

(For additional space, copy form and attach together as needed)