Scout Camp Medication
Authorization & Administration Record

Scout Name: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Parent/Guardian Authorization

I authorize designated adult leaders, camp health officers, or authorized personnel to supervise and/or assist my Scout with the medications listed below while attending camp. I certify that all medications are in their original containers and properly labeled.

Parent/Guardian Signature: _____ Date: _____

Medication #1

Medication Name: _____

Dosage: _____

Administration Time(s): _____

Special Instructions: _____

_____

Medication #2

Medication Name: _____

Dosage: _____

Administration Time(s): _____

Special Instructions: _____

_____

Medication #3

Medication Name: _____

Dosage: _____

Administration Time(s): _____

Special Instructions: _____

Medication Administration Log

Date	Time	Medication	Dose Given	Administered By	Comments

Medication Receipt & Return

Medication Received By: _____

Date Received: _____

Medication Returned To: _____

Date Returned: _____

Notes: _____