



Boy Scouts of America
Troop 1094
Guardian Angels

**Scout
Medication
Control &
Permission**

Scout's Full Legal Name:					
Birth Date:		Home Phone:			
Address:					
City:		State:		Zip:	

Prescription Medication:

**NOTE: All prescribed medication must be kept in the original container bearing the physician's name, directions for use, and the patient's name.*

Name of Medication:					
Reason for the Medication:					
Possible Reaction(s):					
Time of Day	Dosage		Comments		
Comments:					

Prescribing Physician:

Name:		Phone #:			
Address:		City:		Zip:	

Non-Prescription Medication:

Please check the following non-prescription medication that may be given to the above named Scout on an as need basis by an Adult Leader of Troop 1094.

- | | | | |
|-----------------------------------|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Pepto-Bismol | <input type="checkbox"/> Other (write below) |
| <input type="checkbox"/> Motrin | <input type="checkbox"/> Sudafed | | |
| <input type="checkbox"/> Benadryl | | | |

Other: _____

I hereby request that my child be administered his prescribed medication by an Adult Leader of Troop 1094. I understand that the medication will be administered as per the directions as prescribed by the above physician. This form is to cover the August 2004 to August 2005 Scouting year.

Signature of Parent/Guardian

Date