Participant Medication Control Permission Form

Scout's Name:		Week #:
Campsite	First Day:	Last Day:

Medication Required:

Name of Medication:
Reason For Medication:
Possible Common Reaction to Medication:
Dosage:
Time of Administration:
Comments Regarding Medication:

This form has been designed to meet both the requirements of the State of Ohio as well as the Boy Scouts of America. It should offer benefits to the scout in assuring the proper medication at the proper time, and benefit the leader in knowing exactly what the parent is requesting the leader to do, and provide a record that request was carried out. **Note: All prescribed medications must be kept in the original container bearing the physician's name, direction for use, and the patient's name.**

Prescribing Physician:

Doctor's Name:	Phone:	
Address:	City, State:	ZIP:

Parent Permission:

Authorized to administer medication:

Adult #1 Name:	Adult #2 Name:

I hereby request that my scout be administered his prescribed medication at camp by the approved Camp Health Officer or the Adult Unit Leader listed above. I understand that the medication at camp will be administered exactly per the directions as prescribed by the above physician.

Signature of Parent or Guardian:		Date:
Printed Name of Parent or Guardian:		Phone:
Address:	City, State:	ZIP