BSA Troop 536

Loganville, Georgia

Scout Prescription

Scout Prescription Medication Control & Permission Form

Scout's Full Legal Name: _____

Birth Date: _____ Home Phone: _____

Address: _____ City: _____ Zip: _____

*NOTE: ***All medication must be kept in the original container displaying dosage and directions for use.***

Name of Medication: _____

Reason for the Medication: _____

Possible Reaction(s): _____

Time of Day	Dosage	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments: _____

_____

Prescription Medication:

Medication may _____ / may not _____ be given to the above named Scout on an as need basis by an Adult Leader of Troop 536.

I hereby request that my child be administered the above referenced non-prescription medication by an Adult Leaders of Troop 536. I understand that the medication will be administered as per the directions described above or on the medication label.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

(Rev. 08/06/09)