

BEAR PAW MEDICATION CARD

Troop number _____ Site _____

Scout's Name _____

Address _____ Phone # _____

Name of drug & dose _____

Date medication is to begin _____ Time of administration _____ AM / PM

Purpose of medication _____

Possible side effects of medication _____

I agree to be available for direct communication from the person dispensing/administering the medication. Specific conditions under which I should be contacted regarding the condition or reactions of the Scout receiving the medication are:

This card must be completed by the physician and parent. The card **must** be brought to camp with any medications. No medicine container will be accepted at camp unless it is in the original container with the name of the patient, physician, prescription number, the date dispensed, name of medicine, and directions for use on the label.

HEALTH OFFICE USE:

Date: _____ Reviewed by: _____

X _____

Physician signature

Parent Signature

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HEALTH OFFICE USE:

Date: _____ Reviewed by: _____

X _____

Physician signature

Parent Signature

**Medication Card – Side 2
(Camp use only!!!!)**

Scout's Name _____

Fill in date, time, and initial whenever medication is administered.

Date	Time	Initial	Date	Time	Initial	Date	Time	Initial

Full name of person(s) responsible for administering medication:

**Medication Card – Side 2
(Camp use only!!!!)**

Scout's Name _____

Fill in date, time, and initial whenever medication is administered.

Date	Time	Initial	Date	Time	Initial	Date	Time	Initial

Full name of person(s) responsible for administering medication:
