Cub Scout Day Camp Medication Form

Child's Full Name _____

Parent/Guardian Name: _____

Phone Number: _____

Name of medication: _____

Medical reason:
_____
_____
_____
_____
_____

Dosage to be given: _____

Dosage instructions:
_____
_____
_____
_____
_____

Dates at camp he will be taking the medication. Check the ones that apply.

_____ Monday: Time to be given: _____

_____ Tuesday: Time to be given: _____

_____ Wednesday: Time to be given: _____

_____ Thursday: Time to be given: _____

_____ Friday: Time to be given: _____

Parent/Guardian Signature: _____Date: _____

Print Parent/Guardian Name:_____