Routine Drug Administration Record

Name: ______________________________ Campsite: ______________________________

Troop No.: ____________ Date of birth: ____________ Classification: ____________________

Drug hypersensitivity: ____ Weight: __________

INSTRUCTIONS: Sheet is for reproduction as needed. It should be three-hole punched and kept in a binder during camp week. Use one sheet for each camper with a prescription. Record all medicines brought to camp (up to FOUR medications per sheet). The medication, dosage and dosage schedule should be copied from the prescription. Record dispensing times and days in the blocks provided for each medication as they are dispensed. After camp, place sheet(s) inside the first aid log.

Please send the quantity needed for the course ONLY

Prescribing Physician: ______________________________
Medications: ____________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: ____________________ Date Filled: ____________
Comments:

Amount in bottle: ____________

Prescribing Physician: ______________________________
Medications: ____________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: ____________________ Date filled: ____________
Comments:

Amount in bottle: ____________

Prescribing Physician: ______________________________
Medications: ____________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: ____________________ Date filled: ____________
Comments:

Amount in bottle: ____________

Prescribing Physician: ______________________________
Medications: ____________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: ____________________ Date filled: ____________
Comments:

Amount in bottle: ____________

FOR STAFF USE ONLY

Med Time	**S** F	**M** S	**T** S	**W**	**T** F	**F** S	**S** S

Med Time	**S** F	**M** S	**T** S	**W**	**T** F	**F** S	**S** S

Med Time	**S** F	**M** S	**T** S	**W**	**T** F	**F** S	**S** S

Med Time	**S** F	**M** S	**T** S	**W**	**T** F	**F** S	**S** S

FOR STAFF USE ONLY

Medication(s) checked in by: ____________________ Position: __________ date: __________ Initials of both Staff/Participant: ________/________

Medication(s)/Containers returned to scout by: ____________________ Position: __________ date: __________ Initials of both Staff/Participant:: ________/________

MEDICAL PERMISSION SLIP

National Youth Leadership Training is conducted by volunteers formed into provisional troops/crews. These troops/crews operate as a model for all troops/crews in the Greater St. Louis Area Council. As in your Scout's home troop/crew, sometimes it is necessary to provide medical attention for minor aches and pains. For that purpose, we have listed several medications below for you to choose from should the need arise to give them to your Child. We recommend that you use the weight based chart on the back of this form as a guide on which dosage to select. It is also necessary that we have permission to dispense the doctor prescribed medication that you have listed below.

Scout's/Crew Member's Name _____ Weight (lbs.)_____
They are in good physical condition at the present time. They may receive emergency medical treatment at my expense. I also give my permission for the Adult Leaders of his/her NYLT Troop/ Crew to dispense the listed medications to my Child. All these medications and listed strengths are over the counter medications.

Please check all that apply.

- ☐ Tylenol (acetaminophen) 325mg tablets:
- ☐ Tums Tablets (calcium carbonate)
- ☐ Ibuprofen/Advil/Motrin 200mg tablets
- ☐ Benadryl Cream (diphenhydramine)
- ☐ Triple Antibiotic Ointment
- ☐ Medicated Powder
- ☐ Hydrocortisone Ointment/Cream
- ☐ Imodium AD (loperamide)
- ☐ Benadryl (diphenhydramine) 25mg tablet

In addition, my Child is taking prescription medication listed on the previous page that is provided for you in their original containers.

_____
SIGNATURE OF PARENTS OR GUARDIAN

EMERGENCY ADDRESS (Fill out only if different from your own)

_____

Phone number where I can be reached_____