Camp Medication Authorization Form (copy as needed)

Camp NoBeBoSco
Northern New Jersey Council - Boy Scouts of America

Authorization to Medicate

I hereby authorize the Camp Health Officer of Camp NoBeBoSco or his designee to administer to my son _____ of Troop/Crew _____ the following medication(s) according to the instructions provided below. Please note that the instructions on the container of the medication will, by law, be followed unless authorization to alter those instructions is provided by your son's physician. I acknowledge that it is my son's responsibility to report to the Health Office for medication at the appointed time(s).

Name of Medication	**Dose**	**Time to be Administered (Check all that apply)**
_____	_____	❑ After Breakfast
		❑ After Lunch
		❑ After Dinner
		❑ Before Bed Other: _____
		❑ As Needed _____
Name of Medication	**Dose**	**Time to be Administered (Check all that apply)**
_____	_____	❑ After Breakfast
		❑ After Lunch
		❑ After Dinner
		❑ Before Bed Other: _____
		❑ As Needed _____
Name of Medication	**Dose**	**Time to be Administered (Check all that apply)**
_____	_____	❑ After Breakfast
		❑ After Lunch
		❑ After Dinner
		❑ Before Bed Other: _____
		❑ As Needed _____
Name of Medication	**Dose**	**Time to be Administered (Check all that apply)**
_____	_____	❑ After Breakfast
		❑ After Lunch
		❑ After Dinner
		❑ Before Bed Other: _____
		❑ As Needed _____
Name of Medication	**Dose**	**Time to be Administered (Check all that apply)**
_____	_____	❑ After Breakfast
		❑ After Lunch
		❑ After Dinner
		❑ Before Bed Other: _____
		❑ As Needed _____

Please provide any additional instructions below:

_____

_____

_____ _____ _____
Signature of Responsible Party Relationship to Scout Named Above Date