

MEDICINES / ADMINISTRATION PERMISSION FORM

Scout's Name _____ Age _____

Please administer the medication(s) listed below to the Scout named above.

_____ signature of Parent or Guardian

_____ date

Prescription medications should be in dated, labeled containers.

Medicine	Prescription #	Dosage	Times/ day	Time to administer	Administered by
					<input type="checkbox"/> Fri
					<input type="checkbox"/> Sat
					<input type="checkbox"/> Sun
Comments					

Medicine	Prescription #	Dosage	Times/ day	Time to administer	Administered by
					<input type="checkbox"/> Fri
					<input type="checkbox"/> Sat
					<input type="checkbox"/> Sun
Comments					

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					<input type="checkbox"/> Sat
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