Supplemental Medical Information

BOY SCOUTS OF AMERICA®
OLD HICKORY COUNCIL

Part 1 - To be completed for all campers:

Name: _____ Age: _____

Camp: _____ Campsite: _____ Unit: _____

Part 2A - To be completed by Parent/Guardian of Scouts under age 18:

List Medicine, Food, or Environmental allergies and reaction:

_____

_____

List your prescribed medications by a Physician, NP or a PA: (Attach additional sheets if needed)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Part 2B - To be completed by the Unit Leader of Scouts under the age of 18:

As the Adult Unit Leader for the Scout named above, I recognize that they are currently taking the medication(s) listed above. I agree to take the responsibility for these medications, including locking them for storage and making certain that the Scout takes them as prescribed.

Signature: _____ Date: _____

Part 3 - To be completed by the Parent/Guardian of Scouts under the age of 18:

Permission is given to Health Services for over-the-counter medications per package instructions, to my child, should they be needed while at camp.

List any over-the-counter medications **you do not want administered:** _____

_____

Parent/Guardian Signature: _____ Date: _____