

Name of Scout _____ Troop _____

Medication name/ Strength:

When medication is to be taken (e.g. after breakfast every day):

Other specific instructions (e.g. needs to be taken after eating):

Time:	Breakfast	Lunch	Dinner	Bedtime
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Signature of Parent/Guardian _____ Date: _____

.....

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Monday				
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Responsible Troop leader will initial in the appropriate box when medication is administered.

Signature of Parent/Guardian _____ Date: _____