

ROTARY SCOUT RESERVATION
PERSONAL STANDING ORDERS

Scout's Name (last, first): _____ Troop: _____

Date of birth: ___/___/___ Allergies: _____

Over the Counter Medications

The following are over the counter medications which the Scout has brought to camp and which he may take according to the guidelines specified:

Drug Name	Form*	Dosage	Schedule and Indications#	Comments

Prescription Medications

Describe the Scout's current prescription medication regimen for both scheduled and 'p.r.n' (as needed) medications (All prescription medications must be carried in original packaging with pharmacist's label):

Drug Name	Form*	Dosage	Schedule and Indications#	Comments

* describes the form of medication, such as 'syrup,' 'chewable tablet,' or 'pill.'

describes the symptoms which call for each medication and the schedule for administration following the onset of symptoms.

Note: All camper medications will be stored securely in the Camp Health Office.

Camper's Health Care Provider Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____