

**B. S. A. TROOP 23, MOUNT PROSPECT ILLINOIS
MEDICATION REQUEST FORM**

Scout's Name

Age

_____/_____/_____
Date of birth

The following is a complete list of all the Prescription Medications and/or over-the-counter (OTC) medications the above-named Scout is currently taking or authorized to take when necessary. I understand that no Scout shall be permitted to carry any medication, whether prescription or OTC, **EXCEPT IMMEDIATE RELIEF INHALERS AND IMMEDIATE ALLERGY RELIEF MEDICATION SUCH AS EPI-PENS FOR RELIEF OF BEES-STINGS AND THE LIKE.**

Medication	Dosage	Time of Day	Additional information or comments

List all OTC medications and immediate relief inhalers, epi-pens and similar emergency medications. If necessary, list additional medications on a separate sheet.

I hereby request adult leadership for the activity to administer the medication described for the above named Scout in accordance with the directions for administering such medications listed above. I understand that should my son's physician order and direct administration other than as prescribed on the label, the medication will be administered as provided on the label, unless I provide such directions in writing.

I understand that the adult leadership is administering medication to my child gratuitously and in reliance upon my specific written request, instructions and disclosures. Accordingly, I hereby release and expressly waive any and all claims against Boy Scout Troop #23, Mount Prospect, Illinois, their sponsors, Boy Scouts of America, or against the officers, employees, agents, or other representatives of any of them, or any other persons working under their direction or engaged in the conduct of their affairs, including parents and other volunteers, for injuries, side-effects, ill-effects or reactions of any kind, arising out of the administration of medication to my child, _____, in accordance with these instructions. I further agree to indemnify, hold harmless and agree to defend such persons as to any claim, suit or damages they may be called upon to pay or defend in connection therewith.

I understand that any medication (whether prescription or OTC) must be in the original container and provided to the responsible adult leader for the activity and that the pharmacy prescription or drug manufacturer label must be present on the container for all medications, including immediate relief inhalers and immediate allergy relief medication.

I hereby represent that I have provided complete and accurate information concerning the medications prescribed for the Scout and that he is authorized, permitted and required to take. I hereby represent that the instructions I have provided for administration of the medication are accurate and complete.

Parent or Guardian Signature _____ **Date** _____
(By signing as parent or guardian, I also acknowledge that all medications, whether prescription or OTC, will be held by the adult leadership)