BSA TROOP 71, Beavercreek, Ohio

Routine Drug Administration Record

This form identifies the medications that must be regularly administered to Troop 71 scouts.
THIS FORM IS FOR PRESCRIPTION OR ROUTINELY ADMINISTERED MEDICINES. If your son needs to take non-prescription or over-the-counter drugs on an as-needed basis, please complete the Over-the-Counter (OTC) Medication Authorization.

Name of Scout (Last, First):	**Age**	**Date of Birth** (mm-dd-yyyy)

Address	**Phone**

Name of Event	**Campsite**

1. Parent / Guardian Name, Phone	**2. Parent / Guardian Name, Phone**

Medication Name: _____

Rx: ☐ No ☐ Yes, Rx Number(s): _____

Prescribing Physician: _____

Dosage: _____ Date filled: _____

Route*: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal

Times*: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.

Amount in bottle: _____ Comments: _____

Time(s) to administer:

_____

_____

Medication Name: _____

Rx: ☐ No ☐ Yes, Rx Number(s): _____

Prescribing Physician: _____

Dosage: _____ Date filled: _____

Route*: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal

Times*: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.

Amount in bottle: _____ Comments: _____

Time(s) to administer:

_____

_____

* Routes and Times

P.O. = by mouth	I.M. = intermuscular	S.C. = sub-cutaneous	S.L. = sub-lingual (under-tongue)
PRN = as needed	B.I.D. = two times a day	T.I.D. = three times a day	Q.I.D. = four times a day
A.C. = before meals	P.C. = after meals	H.S. = hours of sleep (taken at bedtime)	

Scout Name:

BSA Troop 71, Beavercreek, OH -- Routine Drug Administration Record

Medication Name: ______________________________

Rx: ☐ No ☐ Yes, Rx Number(s): ______________________________

Prescribing Physician: ______________________________

Dosage: ____________________ Date filled: ______________

Route*: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal

Times*: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.

Amount in bottle: ______________ Comments: ______________

Time(s) to administer:

____

____

Medication Name: ______________________________

Rx: ☐ No ☐ Yes, Rx Number(s): ______________________________

Prescribing Physician: ______________________________

Dosage: ____________________ Date filled: ______________

Route*: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal

Times*: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.

Amount in bottle: ______________ Comments: ______________

Time(s) to administer:

____

____

Medication Name: ______________________________

Rx: ☐ No ☐ Yes, Rx Number(s): ______________________________

Prescribing Physician: ______________________________

Dosage: ____________________ Date filled: ______________

Route*: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal

Times*: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.

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