

Boy Scout Troop 73
PERSONAL STANDING ORDERS

Scout's Name (last): _____ (first) _____ (MI) _____

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

Over the Counter Medications

The following are over the counter medications which may be carried in the troop leader's first aid kits. By initialing below I give permission to troop leaders for my son to take the following medications according to the guidelines specified:

Drug Name	Form*	Dosage	Schedule and Indications	Parent Initials
Advil (Ibuprofen)	Pill	200 mg.		
Tylenol (Acetaminophen)	Pill	500 mg.		
Benadryl (Diphenhydramine Hydrochloride)	Pill	25mg. 50 mg.		
Rolaids (Antacid)	Chewable Tablet			

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

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.

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

Address: _____

Signature: _____ Date: _____