

Camp NoBeBoSco
Northern New Jersey Council - Boy Scouts of America

Authorization to Medicate

I hereby authorize the Camp Health Officer of Camp NoBeBoSco or his designee to administer to my son _____ of Troop/Crew _____ the following medication(s) according to the instructions provided below. Please note that the instructions on the container of the medication will, by law, be followed unless authorization to alter those instructions is provided by your son's physician. I acknowledge that it is my son's responsibility to report to the Health Office for medication at the appointed time(s).

Name of Medication	Dose	Time to be Administered (Check all that apply)
_____	_____	<input type="checkbox"/> After Breakfast <input type="checkbox"/> After Lunch <input type="checkbox"/> After Dinner <input type="checkbox"/> Before Bed Other: _____ <input type="checkbox"/> As Needed _____

Name of Medication	Dose	Time to be Administered (Check all that apply)
_____	_____	<input type="checkbox"/> After Breakfast <input type="checkbox"/> After Lunch <input type="checkbox"/> After Dinner <input type="checkbox"/> Before Bed Other: _____ <input type="checkbox"/> As Needed _____

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_____	_____	<input type="checkbox"/> After Breakfast <input type="checkbox"/> After Lunch <input type="checkbox"/> After Dinner <input type="checkbox"/> Before Bed Other: _____ <input type="checkbox"/> As Needed _____

Please provide any additional instructions below:

Signature of Responsible Party	Relationship to Scout Named Above	Date
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