Appendix 6 to Annex M

PRESCRIPTION MEDICATION AND SCOUT OUTINGS

BOY SCOUTS OF AMERICA – NATIONAL COUNCIL POLICY

CURRENT POLICY

- The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian.
- A Scout leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a Scout takes the necessary medication at the appropriate time.
- Boy Scouts of America does not mandate nor necessarily encourage the Scout leader to do so.
- If your state laws are more limiting, they must be followed.

THIS IS A CHANGE

- Old policy stated that all medications were to be checked in to a health officer or a leader in charge at all Scouting functions.

HEART OF AMERICA COUNCIL GUIDELINES FOR MEDICATION ADMINISTRATION

All Scouts are of course minors. Our policy, as far as Council activities are concerned, is similar to that of most schools.

- All medications for a Scout are to be in the possession of the designated adult leader(s), NOT in the Scout's possession, on all Heart of America Council related activities.
    - The only exception to this rule is for asthma inhalers which the Scout can carry; BUT the adult leaders need to be aware of the fact that the Scout has a condition that requires an inhaler, and is carrying an inhaler.

- The obvious corollary to this policy is that NO Scout should be in possession of any prescription or over the counter medication without the knowledge of the Scoutmaster and/or his designated adult leader(s) responsible for medications.
- This information will be treated as confidential and shared on a "need-to-know" basis with other adult leaders.

All medications must be kept in a locked box, preferably in a locked building, leader's cabin or larger lockable box.

- The medication must be:

    - in a prescription bottle clearly labeled with the Scout's name
    - clearly labeled with the name of the medication
    - clearly labeled with the prescribing doctor and the instructions for use

- If you need a bottle to keep at home, you should ask your pharmacy to supply an empty duplicate bottle. Virtually all of them will do so at no charge.
- A medication authorization form shall be completed for all Scouts who are to receive medications on a Scout outing.

The medication must be administered as ordered on the prescription label.

- Any hand-written instructions which vary from the label, or alteration of the label, are not acceptable.
- If your son's medication regimen or dose has changed, bring the most current bottle.
- Hand-written instructions from the doctor on letterhead or prescription that indicates the change in dosage should be fine if clearly readable and understandable to the leader administering the medication.

If the Scout is taking any over-the-counter or non-prescription medication or vitamin, it must be sent in the original container. An envelope, baggie, hand labeled bottle, or any other container than that which the substance was in at the time of purchase is not acceptable.

A medication log shall be kept by all units regarding the administration of the medication. This log should note the following:

- Date of medication administration
- Time of medication administration
- Name of medication administered
- Dose of medication administered
- Name of person administering the medication
- Signature of the person administering the medication

Please remember to send enough medication to cover the entire period the Scout will be on the Scouting activity.

- This means day trips, week-ends, summer camp, etc.
- It is a good idea to send at least one extra dose in the event the troop is delayed in returning for some reason.

- Many medications are dependent upon maintaining a certain "blood level" in the patient.

    - These include many of the anti-depressants, seizure medications, antibiotics and others.
    - For the sake of your son's health, these medications must be continually given, even on camp-outs. We strongly recommend you do not alter your son's medication regimen for any reason without the knowledge and agreement of his doctor.
    - Units should be willing to see that your son receives his medication for the time he is with the troop on events and activities, to assist him in maintaining optimum health.

ATTACHMENT A TO APPENDIX 6

AUTHORIZATION FOR ADMINISTERING OF MEDICATIONS

Name of Participant______________________________ Unit:________________________________

INSTRUCTIONS

1. ALL Participants MUST complete and submit a signed copy of this form, even if no medications are provided.
2. Medications (Prescription and Over-the-Counter) must be in ORIGINAL labeled container and placed in a zip-lock type bag identified with Scout's name.
3. Any Medications unclaimed at the conclusion of the event will be destroyed.

Check One:

_____No Medications are to be given (including over-the-counter).

_____Authorize Administration of Medication as Indicated

____

Signed: (Parent or Guardian) Date

(NOTE Good for 1 year from signature date.)

Over-The-Counter Medications: Ibprofen, Acetaminophen, Antacid, Decongestant, Calamine

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____

(NOTE: Circle what applies, list others that are also provided

Strength, Age/weight appropriate:___________________

____

Frequency (As Directed by Manufacturer:_____________

____

Any Special Reason for taking this Medication:_________

____

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____

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____

____

Medication:____________________________________	Medication:____________________________________
Strength:______________ Frequency_______________	Strength:______________ Frequency_______________
Reason for taking this Medication____________________	Reason for taking this Medication____________________
____	____
Approximate Date Started:________________________	Approximate Date Started:________________________
Temporary:_______________Permanent_____________	Temporary:_______________Permanent_____________
Side Effects:____________________________________	Side Effects:____________________________________
____	____
Storage Instructions:_____________________________	Storage Instructions:_____________________________
Prescribing Physician:_____________________________	Prescribing Physician:_____________________________
Physician's Phone:_______________________________	Physician's Phone:_______________________________
Medication:____________________________________	Medication:____________________________________
Strength:______________ Frequency_______________	Strength:______________ Frequency_______________
Reason for taking this Medication____________________	Reason for taking this Medication____________________
____	____
Approximate Date Started:________________________	Approximate Date Started:________________________
Temporary:_______________Permanent_____________	Temporary:_______________Permanent_____________
Side Effects:____________________________________	Side Effects:____________________________________
____	____
Storage Instructions:_____________________________	Storage Instructions:_____________________________
Prescribing Physician:_____________________________	Prescribing Physician:_____________________________
Physician's Phone:_______________________________	Physician's Phone:_______________________________

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