Girl Scouts
Heart of Michigan

Medication Record Form

Participant's Name:				Program Date:				
Program Name:				Program Location:				
MEDICATION: dose, route and frequency	Time to be given	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Parent: List medications to be given and how and when to be given		**First Aider/Health Officer**: Initial and note time medicaiton is given						

Parent/Guardian's Signature:_____Date: _____