girl scouts of southern nevada

Medication Release

ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER

Girl's Name:_____

Name of Medication:_____

Purpose of Medication:_____

Directors for Administering:_____

I HEREBY GIVE PERMISSION FOR AN ADULT IN LEADERSHIP CAPACITY OR A FIRST AIDER TO ADMINISTER THIS MEDICATION ACCORDING TO THE ABOVE DIRECTIONS. NO MEDICATION WILL BE ADMINISTERED WITHOUT SPECIFIC INSTRUCTIONS FROM A PARENT OR GUARDIAN.

Please acknowledge you have discussed medication administrations.

Parent/Guardian: _____ Date:_____

Day Phone: _____ Evening Phone:_____

Troop Leader:_____ Date:_____

2941 Harris Avenue Las Vegas Nevada 89101 702 385 3677 girlscoutsnv.org

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