



# Girl Scouts of Greater Chicago and Northwest Indiana

Vernon Hills Regional Service Center  
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www.girlscoutsgcnwi.org

## Authorization for Medications

(Confidential)

Complete a separate form for each medicine and submit to the event coordinator or Girl Scout leader.

Event: \_\_\_\_\_ Date (s): \_\_\_\_\_

### Duplicate this form as needed

Girl Name \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

Physician \_\_\_\_\_

Phone \_\_\_\_\_

This form must be completed and signed by parents/guardians of girls. All Health History forms will be **held in limited access** by the **trustee** (leader/facilitator/staff) of the specific Girl Scout program. The **absolute minimal necessary information** may be shared with program staff/volunteers in order to provide adequate health care. The Health History form will be retained by the Girl Scout program **trustee** until it is destroyed.

I request that my child be assisted in taking the medicine listed below by the authorized person(s).

### Medication Information

Name of medicine: \_\_\_\_\_

Diagnosis for which medicine is given: \_\_\_\_\_

Form (i.e., liquid, tablet, injection): \_\_\_\_\_

Dose: \_\_\_\_\_

What time(s) if medicine is to be given "daily"? \_\_\_\_\_

Indications if medicine is to be given "when needed". \_\_\_\_\_

How soon can the dosage be repeated? \_\_\_\_\_

List significant side effects: \_\_\_\_\_

Length of time treatment is recommended: \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

**\* Important: All medicine must be sent in its original container \***