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## Administration Of Medicine

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Camp Location: \_\_\_\_\_

----- TO BE COMPLETED AND SIGNED BY YOUR PHYSICIAN -----

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage:

1. Amount to be given: \_\_\_\_\_
2. Time to be given: \_\_\_\_\_
3. Duration: Days \_\_\_\_\_ Weeks \_\_\_\_\_

Side Effects:

1. To report: \_\_\_\_\_
2. To expect: \_\_\_\_\_

Physician's Name (PRINT): \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Phone#: \_\_\_\_\_ Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

----- **TO BE COMPLETED AND SIGNED BY PARENTS** -----

I request that one of Club Scientifics' Site Directors administer the medication described above to my child (name of child) \_\_\_\_\_. I will supply the Site Directors with the medication prescribed in the original container or a duplicate professionally labeled and supplied by the pharmacist for this purpose.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_