Club Scientific St Johns, FL
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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: _______________