



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: _____