NAME	
WEEK	
CAMP	

ADMINISTRATION OF MEDICINE

CAMPER NAME _____
DATE OF BIRTH _____
ADDRESS _____
PARENT NAME (print) _____
PARENT PHONE _____

TO BE COMPLETED AND SIGNED BY PARENTS

I request that a Club Scientific Site Director administer the medication described above to my child named above. I will supply the Site Director with the medication prescribed below in the original container or a duplicate professionally labeled and supplied by the pharmacist for this purpose.

PARENT SIGNATURE _____
DATE _____

TO BE COMPLETED AND SIGNED BY 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) _____
ADDRESS _____
PHONE _____

PHYSICIAN SIGNATURE _____
DATE _____

CLUB SCIENTIFIC NORTH RALEIGH

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