---------- Administration of Medicine----------

Camper Full 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 Signature: _____

Physician's Name (PRINT): _____ Date: _____

Physician's Phone#: _____ Address: _____

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

I request that one of Club SciKidz' 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: _____

FAX COMPLETED FORM TO: 214-530-5979 & BRING A COPY WITH YOU ON THE FIRST DAY OF CAMP TO GIVE TO THE SITE DIRECTOR