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 Mielke WAY's REALLY FUN SCIENCE Summer Day Camp 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: _____