THE PREP
SOUTH TAMPA

4002 S. Coolidge Ave. Tampa, FL 33611
(813) 512 - 2924

Name: _____ Date of Birth: ____/____/___

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

----------**TO BE COMPLETED 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: _____

Facility Name: _____ Physician's Phone #: _____

Facility's Address: _____

_____

Physician's Signature: _____

I request that one of The Prep of South Tampa's Directors administer the medication described above to my child, _____. I will supply the site director with the medication prescribed in the original container or a duplicate professionally labeled and supplied by the pharmacist for this purpose.

Parent's Signature: _____ Today's Date: _____