PO Box 885
Sleepy Hollow, NY 10591
(914) 328-3798

# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the parent or guardian:

I request that my child _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse, or other designated person, will administer the medication.

Signature of the Parent/Guardian:_____
Address:_____
Telephone (Home): _____ (Work):_____Date:_____

B. To be completed by physician or health care provided:

I request that my patient:_____ receive the following medication:
Name of Camper:_____ Date of Birth:_____
Diagnosis: _____
Name of Medication: _____ Prescribed Dosage: _____
Frequency and Route of Administration: _____
Time to be taken during camp hours: _____
Duration of Treatment: _____
Possible side effects and adverse reactions (if any): _____
_____

Provider's Signature:_____ Date: _____
Address: _____Telephone: _____

MD STAMP: